**U.S. Department of Labor**

Office of Administrative Law Judges
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**Issue Date: 21 January 2004**

Case No. 2003-LHC-0034
OWCP No. 10-38723

In the Matter of:
THOMAS BORDEAUX,
Claimant,

v.

PITTSBURGH & CONNEAUT DOCK AND
SIGNAL ADMINISTRATION,
Employer,

and
DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES[1]:
Steven Schletker, Esq.
On behalf of Claimant

Gregory Sujack, Esq.
On behalf of Employer

BEFORE: Thomas F. Phalen
Administrative Law Judge

## DECISION AND ORDER – AWARDING BENEFITS

This case arises from a claim for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. §901, *et seq.* ("LHWCA" or "the Act").

On October 2, 2002, this case was referred to the Office of Administrative Law Judges by the Office of Workers' Compensation Programs for a hearing. Following proper notice to all parties, a formal hearing in this matter was held before the undersigned on May 9, 2003 in Cincinnati, Ohio. All parties were afforded full opportunity to present evidence as provided in the Act and the Regulations issued thereunder and to submit post-hearing briefs.

[1] The Director, Office of Workers' Compensation Programs, did not appear at nor was represented by counsel at the hearing.

The findings of fact and conclusions of law set forth in this Decision and Order are based on my analysis of the entire record. Each exhibit and argument of the parties, although perhaps not mentioned specifically, has been carefully reviewed and thoughtfully considered. References to ALJX. 1-9, CX A-Z, EX 1-7, and JX 1 pertain to the exhibits admitted into the record and offered by the Administrative Law Judge, Claimant, Employer, and joint exhibits respectively. The Transcript of the hearing is cited as Tr. followed by page number.

## STIPULATIONS

At the hearing, the parties submitted the following stipulations.

1. The parties are subject to the Longshore and Harbor Workers' Compensation Act (33 U.S.C. §901 *et seq.*) as extended by the Defense Base Act;

2. Claimant filed a claim for compensation (form LS-203) with the United States Department of Labor on November 6, 2000;

3. Claimant's claim was timely filed;

4. The date of the alleged injury/accident is September 12, 2000;

5. The injury/accident arose out of and in the scope of employment;

6. Claimant and Employer were in an employee-employer relationship at the time of the accident/injury;

7. Employer was advised of or learned of the injury immediately;

8. Timely notice of injury was given to the Employer;

9. Employer filed a notice of controversion on May 31, 2002 and withdrew the notice of controversion in July 2002;

10. The notice of controversion was timely filed;

11. Employer filed a first report of injury (Form LS-202) on September 15, 2000;

12. Informal conferences were conducted on April 23, 2002 and September 19, 2002;

13. Claimant's average weekly wage at the time of the accident/injury was $638.28;

14. The Claimant briefly describes the nature and extent of his injury as follows:

Claimant was working in a sump pump pit when a co-worker dropped a water soaked sand bag weighing over fifty pounds approximately ten to fifteen feet. The falling sand bag struck Mr. Bordeaux in the head and back of the neck.

Upon impact, Claimant fell to the ground fracturing the right wrist and injuring the right arm. Claimant suffers from permanent anatomical injury to the right wrist/arm, neck, and upper back. Mr. Bordeaux also suffers from cognitive impairment as a result of the closed head injury suffered in the September 12, 2000 industrial accident. Claimant's cognitive deficits include inability to maintain focus, attention and concentration, memory loss, mental fatigue and persistent headaches. Claimant was temporarily totally disabled from September 12, 2000 through August 20, 2002, at which time maximum medical improvement was reached. Claimant has been permanently totally disabled from August 21, 2002 through the present and continuing. As a direct and proximate result of the work injury of September 12, 2000, Claimant also suffers from 16% permanent partial scheduled impairment to the right arm compensable under Section 8(c)(1).

16. The parties agree that Claimant has suffered temporary total disability from September 12, 2000 to August 20, 2002;

17. Claimant received temporary total disability benefits from September 12, 2000 to the present at the rate of $425.01 per week;

18. All Section 7 medicals are paid to the present knowledge of Claimant;

19. Claimant has not returned to his regular employment with Employer since the date of the injury;

20. Employer filed a Notice of Final Payment or Suspension of Compensation Payments (Form LS-208) on May 31, 2002 and it was withdrawn after an informal conference; and

21. Employer does not claim relief under § 8(f).

(JX 1).

## ISSUES

The issues in this case are:

1. Whether Claimant is permanently totally disabled[2];

2. Whether Claimant is entitled to benefits under Section 8(c)(1) for disability to the right arm and 8(c)(3) for disability to the right hand;

3. Whether Claimant has reached maximum medical improvement; and

4. Whether counsel for Claimant is entitled to attorney fees.

[2] At the hearing, counsel for Employer stated that he agreed that Claimant was presently totally disabled, adding that the issue is whether his total disability is temporary or permanent. (Tr. 88).

(JX 1). Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

An Administrative Law Judge is entitled to determine the credibility of the witnesses, to weigh the evidence and draw his own inferences from it, and he is not bound to accept the opinion or theory of any particular medical examiner when determining whether the employee has sustained an injury compensable under the LHWCA. *Banks v. Chicago Grain Trimmers Association, Inc.*, 390 U.S. 459 (1968), *reh. denied*, 391 U.S. 929 (1969). The claimant bears the ultimate burden of persuasion by a preponderance of the evidence. 5 U.S.C. § 556(d).

Background

Thomas Bordeaux ("Claimant") was born on May 11, 1943; he was fifty-nine years-old at the time of the hearing. (Tr. 23). Claimant married Heather Bordeaux almost thirty years ago, and they have two children who no longer live at home. (Tr. 24, 64). Claimant completed the eighth grade and part of the ninth grade. (Tr. 24). He attempted to obtain his GED, but was unsuccessful. (Tr. 25). Claimant served in the United States Army, where he suffered a service related hearing loss. (Tr. 27, 55). He worked as an apprentice pipe fitter after leaving school. (Tr. 25). He then obtained certifications as a merchant seaman, able-bodied seaman, and pressure vessel welding, as well as in pipefitting. (Tr. 25, 26). Claimant stated that all of his employment has involved physical work, including lifting heavy pipes and wrenches, working overhead, and climbing. (Tr. 26). All of his employment required manual dexterity. (Tr. 26). Most of his work involved working on ships fabricating steel. (Tr. 26).

Claimant began working for Pittsburgh & Conneaut Dock & Signal Administration ("Employer") in 1997 as a structural welder. (Tr. 28). His work involved repair, welding, fabricating, and working on equipment that loads or unloads material for ships. (Tr. 28). After a year, Claimant moved to the position of pipe fitter. (Tr. 29). As a pipe fitter, he was responsible for taking care of all of the grease lines, water lines, gas lines, and all pumps and compressors. (Tr. 29). His daily work required heavy lifting and climbing. (Tr. 29). His tools alone each weighed forty to fifty pounds each. (Tr. 30).

On September 12, 2000, Claimant was working at a pump station. (Tr. 31; CX Z). He was using a "suck truck to clear debris" from the intake pipes of the pump station. (Tr. 31).[3] The pump station that Claimant was working at was a bunker pit system that he described as twenty feet long by six feet wide and fifteen feet deep. (Tr. 33). The pit is covered by a grate. (Tr. 33). Claimant removed the grate, climbed down a ladder that was affixed to the wall of the pit, and was using the hose to remove debris. (Tr. 35-38). Claimant was wearing all of his safety equipment, which included a hard hat, glasses, and hip boots. (Tr. 39). While he was

[3] Claimant stated that the suck truck was a large truck with a vacuum cleaner that has an eight inch hose, which is used to remove debris. (Tr. 32).

working at the bottom of the ladder, another employee had climbed down the ladder and was working about a foot over Claimant's head. (Tr. 39). The other employee dropped a wet sandbag weighing over fifty pounds. (Tr. 39). Since Claimant was bent over using the hose, the sandbag struck Claimant on the bottom portion of his hard hat, the base of his head that wasn't protected by the hard hat, and on his neck. (Tr. 39-40). Claimant vaguely recalls climbing out of the pit and being taken by ambulance to the emergency room. (Tr. 40). He remembers that he was experiencing extreme pain in his head, neck, and right wrist. (Tr. 40). Claimant moved in and out of consciousness. (Tr. 40). Claimant was treated in the emergency room and sent home. (Tr. 41). He returned to the hospital the next day to have his wrist placed in a cast and because he was having difficulty formulating any kind of a sentence. (Tr. 41, 42).

At the time of the hearing, Claimant testified that no surgery was planned for him. (Tr. 46). He continued to experience pain, stiffness, and headaches. (Tr. 46). Claimant testified that he has constant numbing and tingling in his head. (Tr. 48). If Claimant sits for a long time, he has to lie down to relieve the symptoms. (Tr. 48). He also has pain on the right side in the back of his neck that extends down into his shoulder. (Tr. 48). Claimant testified that the problems with his head and neck cause pain that prevents him from bending over. (Tr. 49). Any time Claimant tries to lift something, especially with his right side, it causes pain. (Tr. 49). He stated that the pain from his head and neck only allows him to stand for a couple of hours. (Tr. 49). Claimant stated that he continues to have problems with his right wrist to the point that he can't even hold a pencil. (Tr. 49). He also continues to have problems with his memory and attention. (Tr. 49). He reported that he was no longer depressed and that he didn't have any anxiety. (Tr. 47). At the time of the hearing, Claimant was using Darvocet for his neck and Motrin for his head and neck. (Tr. 51).

Claimant has not returned to any form of work since September 12, 2000. (Tr. 50). He testified that he could not perform any requirement of his position as a pipe fitter for Employer. (Tr. 50). He is still able to drive, but he avoids freeways because he can't concentrate for periods of time behind the wheel. (Tr. 50, 51). Claimant described his post-accident typical day as consisting of driving to the coffee shop to "sit around with some of the fellows [he] know[s]." (Tr. 51). He then returns home, where he may work in the yard for a little bit. (Tr. 52). He also does work around the house and runs errands. (Tr. 53).

Robert Myers was deposed on March 10, 2003. (CX W). Mr. Myers worked for Employer at the time of his deposition as a pipe fitter who worked with Claimant on the same assignments. He testified regarding the physical requirements of a pipe fitter as requiring the lifting of a pipe and working on pumps and air compressors. Mr. Myers stated that lifting devices were used if heavy pipes had to be lifted. He would carry pumps around with him that weighed around one-hundred pounds. Pipe fitters for Employer had to climb stairs and walk up inclines to grease lines. Mr. Myers never noticed Claimant ever have a problem with his right wrist or his neck that prevented Claimant from doing his work. He described the position of pipe fitter for Employer as really physical and involves more of mental aspect than normal pipe fitting. Mr. Myers testified that he never noticed Claimant to have any problems maintaining attention or focus to instructions he had been given. He also never witnessed Claimant experience problems with memory. Mr. Myers characterized Claimant as a good worker.

Claimant's son drove Claimant to Mr. Myers house on two occasions after Claimant was injured, once to go to a gun show. Mr. Myers described Claimant as stiff-moving and slow-moving.

James Call was also deposed on March 10, 2003. (CX X). Mr. Call is a retired maintenance supervisor who worked for Employer thirty-two years before retiring. He provided a general description of the maintenance work that Employer provided. Mr. Call testified that Claimant was able to do his job and he did not recall any time when Claimant complained of any problem with his head or neck. He testified that pipe fitter employed by Employer would be required to dig trenches, change pipes, install heaters, hitch car-wash stations, and any plumbing that needed to be done such as repairing urinals. Lifting in excess of seventy-five pounds was required on occasion. Pipe fitters use heavy wrenches, including a 36-inch pipe wrench. A pipe fitter would also be required to bend, crouch, stoop, work overhead, and work below. Mr. Call testified that the mental aspects of a pipe fitter included knowing what actions were safe, such as when to open a waterline. He never observed Claimant exhibit any problems with following instructions or with memory.

Claimant's wife, Heather Bordeaux, testified at the formal hearing that Claimant was in good physical shape prior to September of 2000. (Tr. 65). She stated that he didn't have any problems with his memory or his ability to focus and concentrate after the accident. (Tr. 65). Mrs. Bordeaux testified that Claimant's speech therapy resulted in an improvement for six-to-eight months through 2000 into 2001, and then Claimant's improvement "planed off." (Tr. 69). Through 2000 and into 2001, Claimant was still having memory problems, difficulty focusing, and he continued to have head aches and pain in his neck. (Tr. 69). Mrs. Bordeaux testified that Claimant's head aches and neck aches improved after the accident through 2000 into 2001, but she did not observe any additional improvement after the beginning of 2001. (Tr. 69, 70). She testified to a similar period of improvement over the first six-to-seven months in Claimant's memory and focus followed by a leveling off in improvement. (Tr. 72). Mrs. Bordeaux testified that Claimant still needs to be very careful because he forgets things like leaving the water running in the sink, and leaving the television on. (Tr. 73). She added that Claimant will frequently ask her to explain a piece of news and then later on in the day he will not remember the explanation. (Tr. 73). Mrs. Bordeaux stated that Claimant helps with chores around the house, like putting a pan of chicken or potatoes into the oven. (Tr. 74). She reports that Claimant takes longer to read the newspaper than usual, and sometimes he will ask her to explain the story even after he read it two or three times. (Tr. 75). Mrs. Bordeaux testified that Claimant did not experience this type of difficulty reading the newspaper before September 2000. (Tr. 77). Overall, Mrs. Bordeaux stated that she feels as if she has to watch Claimant and that she is concerned that he will forget things, such as picking her up, which did not occur before September 2000. (Tr. 78).

Procedural History

This claim was transferred to the Office of the Administrative Law Judges on October 2, 2002. Administrative Law Judge Robert Hillyard issued a notice of hearing and pre-hearing order on December 10, 2002. (ALJX 1). On March 10, 2003, Employer filed a motion to extend time to file its prehearing documents. On March 13, 2003, Employer filed a motion for continuance of the hearing scheduled to begin on March 19, 2003. (ALJX 6). Specifically,

Employer requested a five-month continuance to allow Claimant to undergo a 12-16 week course of psychotherapy based on the recommendation of Dr. McCue. Also on March 13, 2003, Employer filed an agreed motion for leave to submit post-hearing evidence, wherein Employer stated that Claimant had agreed to allow Employer to take and submit the post-hearing depositions of Drs. McCue, Langa, Lyons, and Lubahn. (ALJX 6). On March 17, 2003, Claimant filed a response in opposition to Employer's motion for continuance. (ALJX 7). Claimant objected to the continuance on the basis that Claimant had reached maximum medical improvement and because Claimant was ready to proceed with the hearing. Claimant also filed a response in clarification of Employer's motion for leave to submit post hearing evidence on March 17, 2003. (ALJX 7). On March 18, 2003, Employer filed a reply in support of its motion for continuance. (ALJX 8). On March 18, 2003, Administrative Law Judge issued an order denying Employer's motion for continuance and granting Employer's motion to submit post-hearing evidence. (ALJX 4). Also on March 18, 2003, Administrative Law Judge Hillyard issued an order re-assigning the claim to the undersigned Administrative Law Judge for hearing and disposition. (ALJX 3). On March 19, 2003, Claimant filed a response to Employer's reply in support of Employer's motion for continuance. (ALJX 9). On May 21, 2003, Employer requested an extension of the deadline to submit its post-hearing evidence until June 2, 2003. Employer filed the post-hearing depositions of Drs. Lyons, Langa, and McCue. Since Claimant had no objection, the undersigned issued an order on June 3, 2003 granting Employer an extension until June 2, 2003 to submit its post-hearing evidence.

Claimant filed a post-hearing brief on June 18, 2003 and Employer filed a post-hearing brief on June 20, 2003. On July 1, 2003, counsel for Claimant filed a petition for attorney fees and litigation expenses. On July 28, 2003, Employer filed a motion to hold in abeyance any consideration of an award of attorney fees until such time as Employer is determined to be liable for employer-paid attorney fees under Section 28. In the alternative, should the undersigned determine that a response to the fee application is required, Employer requested 21 days from the undersigned's order to respond to counsel for Claimant's fee application. Claimant filed a supplemental petition for litigation expenses on August 21, 2003. On December 31, 2003, Employer filed a motion to compel medical care and treatment.[4] Employer requested that the

[4] It is of initial importance to note that Employer's motion to compel was not timely filed, since Employer filed the motion seven months after the formal hearing. Administrative Law Judge Hillyard previously denied Employer's motion for a five-month continuance to allow Claimant to undergo psychotherapy with Dr. McCue on March 18, 2003. Therefore, the undersigned will not consider Employer's motion to compel. However, Employer has not established that Claimant has unreasonably refused medical treatment as is required by 33 U.S.C. § 907(d)(4) before an administrative law judge may suspend compensation. Moreover, Employer has not cited to any regulatory or case law authority to identify any other authority for the undersigned to compel a claimant to undergo medical treatment. The course of treatment recommended by Drs. Schwabenbauer and McCue, which Employer seeks to compel Claimant to follow, is not medically necessary. Rather, it is designed to minimize or alleviate the symptoms of anxiety and depression Claimant suffers from. Even if these symptoms were to be resolved or minimized through the recommended course of treatment, the overall impact on the permanency of Claimant's disability is dubious. The recommended course of treatment will not improve Claimant's SLAC wrist, his cervical spine injury, and it is only believed to offer the possibility of some improvement to Claimant's cognitive limitations. As the record exists, Claimant would still be unable to return to his previous job as a pipe fitter even if his symptoms of anxiety and depression were alleviated due to his neck, wrist, and cognitive limitations. The record does not contain any evidence of suitable alternate employment that Claimant could realistically compete for if his symptoms of anxiety and depression were removed and he experienced some improvement in cognitive function. Therefore, as the record exists, even if Claimant underwent the recommended course of treatment, he would still be suffering from a permanent total disability. While the undersigned recognizes the obvious potential gains Claimant could realize

undersigned issue an order directing that Employer's obligation to pay compensation be suspended until such time as Claimant agrees and actually does pursue a course of psychotherapy appropriate to relieve the neuropsychiatric conditions from which Claimant is suffering. In the alternative, and preferable to Employer, Employer requested that the undersigned issue an order directing Claimant to participate in an appropriate course of psychotherapy. On January 6, 2003, Claimant filed a response in opposition to Employer's motion to compel medical treatment. Since I have denied Employer's motion to compel medical care and treatment, the request for an order to stay Employer's obligation to pay compensation is hereby denied.

Medical Evidence

Claimant presented to John Meranda, M.D. on September 26, 1997. (CX Y). Claimant completed a medical history form. He did not list any present physical complaints or disabilities. The only physical conditions that he marked were for a service related hearing loss and high blood pressure. Dr. Meranda conducted a pre-employment physical examination. His impression was that Claimant had controlled hypertension. Dr. Meranda approved Claimant's physical fitness for employment.

On August 5, 1998, Claimant returned to Dr. Meranda's office. (CX Y). Claimant reported feeling severe pain in his central, lower back on July 25, 1998. Claimant stated that he was treated by a chiropractor and released on August 4, 1998. Upon physical examination, Dr. Meranda found the range of motion in Claimant's spine and back to be good. His impression was resolved low back strain and controlled hypertension.

The Conneaut Rescue Squad responded to the scene of Claimant's industrial accident on September 12, 2000 at 11:18 am. (CX A). The rescue squad reported that Claimant was the victim of an industrial accident involving a single sand bag that fell ten feet and struck Claimant

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from undergoing the treatment course recommended by Drs. Schwabenbauer and McCue, the record fails to show that Claimant should be compelled to attend such treatment by suspending his compensation. Claimant's ability to work is not the standard by which the nature of Claimant's disability is determined. While his ability to work is certainly probative of the extent of Claimant's injury, there is insufficient evidence to establish that even a complete resolution of Claimant's anxiety and depression would allow Claimant to return to work. There is evidence that the recommended treatment may help Claimant return to some form of sedentary or light work, but this evidence is speculative, it is not supported by any vocational analysis, and it is contradicted by the opinion of Dr. Durgin. Even though Employer seeks to compel Claimant to undergo the recommended treatment, the regulation invoked by Employer to support its motion does not provide the undersigned with the authority to compel Claimant to do anything. Rather, 33 U.S.C. § 907(d)(4) allows for the suspension of compensation when a claimant unreasonably refuses to submit to medical or surgical treatment. Claimant's refusal to attend the treatment regimen recommended by Drs. Schwabenbauer and McCue is not unreasonable. The treatment regimen is expected to last up to one year and would require Claimant to take antidepressants. Claimant has already been prescribed several different antidepressant medications, but the prescribing physicians discontinued those prescriptions after Claimant was unable to tolerate the medication. Claimant testified at the hearing that he is not depressed. Also, Claimant attended two sessions of psychotherapy with Dr. Schwabenbauer, Nanette Crawford worked with Claimant during three blocks of sessions to improve Claimant's ability to live with his limitations in manners similar to the type of cognitive therapy that Dr. McCue recommended, and Claimant also attended numerous physical therapy sessions. Claimant demonstrated a clear willingness to heal and improve his physical and mental condition. Thus, I find that Claimant's refusal to undergo psychotherapy, antidepressant therapy, cognitive rehabilitation therapy, and work-hardening is not unreasonable.

in the head and back of neck. Claimant reported a loss of consciousness and complained of blurred vision. His chief complaint was pain in his head and neck.

Claimant arrived at the University Hospitals of Cleveland at 11:46 am on September 12, 2000. (CX B). He complained of blurred vision and nausea. Carl Doelle, M.D. interpreted x-rays and CT-scans of Claimant's cervical spine, finding no fractures to be present. He opined that a CT-scan of Claimant's brain revealed no acute intracranial pathology. His impression from several x-ray views of Claimant's right wrist was: (1) Radioscaphoid joint narrowing. Presumed chronic change lateral aspect of scaphoid as described; and (2) There is a benign sclerotic density of the distal right ulnar diaphysis. Samuel Namey, M.D., examined Claimant and diagnosed a contusion of the neck with loss of consciousness, a fracture of right scaphoid, and a cervical strain. Dr. Namey prescribed Darvocet.

The following morning on September 13, 2000, Claimant returned to the University Hospitals of Cleveland for cast application to his right wrist. (CX C). Claimant returned to the hospital that evening complaining of difficulty communicating because he would forget what he was saying in mid-conversation. (CX D). Jeffrey Stover, M.D. examined Claimant and referred him for a head CT-scan. Dr. Ann McGeehan's impression from the head CT-scan was that there is no evidence of an acute intra-cranial abnormality. Dr. Stover noted that the head CT-scan was normal. He diagnosed a head contusion/concussion and discharged Claimant to follow-up with his family physician.

Claimant submitted the office and treatment notes of Dr. Choi from the Ashatabula Clinic, which span from July 14, 2000 through November 7, 2002. (CX E). Dr. Choi examined Claimant on September 16, 2000. He documented an accurate account of Claimant's September 12, 2000 accident and the resulting treatment at Brown Memorial Hospital in Conneaut. Dr. Choi noted that Claimant was ambulatory and had a splint on his right wrist. Claimant reported that he was feeling better after being concerned the first few days after the accident by his inappropriate speech and disorientation. Dr. Choi found Claimant to be alert with no signs of confusion. His impression was recent head injury with concussion and strain of the neck muscles and fracture of the wrist. Dr. Choi suggested that Claimant continue directions from the doctors in Conneaut.

Claimant presented to the Ashatabula County Medical Center Physical Therapy/Sports Medicine Center on September 25, 2000 for his initial physical therapy evaluation at the referral of Dr. Meranda. (CX F). The therapist documented an accurate account of Claimant's September 12, 2000 accident. Claimant's chief complaint was recorded as cervical spine pain, stiffness, and tenderness, decreased cervical spine range of motion, as well as frequent headaches and trouble sleeping. Claimant reported his current pain level, with "10" being maximal pain, as a "7". The therapist noted that Claimant presented with a decreased ability to perform ADL's, difficulty sleeping, and difficulty driving secondary to restrictions with cervical spine range of motion. The therapist scheduled Claimant for physical therapy three times per week for four weeks. The therapist discharged Claimant from physical therapy on October 9, 2000 after Claimant called and informed the therapist that his physician had put therapy on hold. The therapist noted that Claimant had not met all of his goals. Claimant had attended four sessions.

The office notes of N. Rehmatullah, M.D., who is board-certified in orthopedic and neurological surgery, show that he saw Claimant on October 2, 2000 for a follow-up visit. (CX H). He recommended that Claimant continue with his therapy.

Claimant returned to Dr. Choi on October 6, 2000 through the referral of Employer's case manager, Judith Meals. (CX E). Claimant was complaining of pain in the back of his head and neck, with tingling off-and-on in the fingers of his left hand. Dr. Choi's working diagnosis was concussion, cervical sprain/strain and arthritis/foraminal narrowing. His plan included a MRI/MRA of Claimant's head and neck. Dr. Choi prescribed Celebrex and Darvocet. He recommended that Claimant's physical therapy be put on hold and that Claimant be off of work.

Amy Clunn, M.D. conducted and interpreted an MR of the brain, MR angiogram of the circle of Willis and posterior fossa, and MR of the cervical spine on October 14, 2000. (CX E). Her impression was unremarkable MR of brain, no evidence of hemodynamically significant intracranial stenosis, and degenerative disc disease at C5-6 with bilateral bony foraminal stenosis.

Claimant returned to Dr. Rehmatullah's office on October 16, 2000. (CX H). Dr. Rehmatullah noted that Claimant was doing better. He found Claimant's neck to be clinically better. He also found Claimant's right wrist to be doing better. Dr. Rehmatullah recommended symptomatic care, but noted that Claimant remains disabled from work.

Dr. Clunn prescribed three-to-four weeks of physical therapy on October 20, 2000 with special instructions for occupational MER, stretching, reconditioning, and range of motion related to Claimant's cervical spine. (CX F). On October 30, 2000, Dr. Clunn also prescribed two-to-four weeks of therapy to teach Claimant compensatory strategies. Dr. Clunn's diagnosis was post-concussive syndrome.

Claimant returned to the Ashatabula Clinic on October 30, 2000. (CX E). Claimant reported that he had gotten a little better, but he still complained of pain and headaches that wake him up three-to-four times per week. Dr. Choi's assessment was that Claimant has a cervical sprain/strain, neuralgia, and post-concussion syndrome. Dr. Choi recommended physical therapy, speech therapy, and refilled Claimant's prescriptions for Darvocet and Motrin, as well as noting that trigger point injections would be performed next visit if needed.

Dr. Rehmatullah examined Claimant on October 30, 2000. Overall Claimant was improving, but his wrist still bothered him. (CX H). An x-ray of Claimant's wrist showed that his navicular remained the same. Dr. Rehmatullah found degenerative changes in the wrist that had been there before that were aggravated by the injury.

Claimant returned to the Ashatabula County Medical Center Physical Therapy/Sports Medicine Center on November 6, 2000 for another initial physical therapy evaluation. (CX F). Claimant's chief complaint was cervical spine pain, stiffness, and tenderness that was aggravated with cervical spine range of motion especially into extension, as well as intermittent headaches. Claimant rated his pain as a "5". Claimant also presented for an initial consultation on November 6, 2000 with the Speech – Language Department of the Ashatabula County Medical

Center with Nanette Crawford. (CX G). The medial diagnosis on initial consultation was "post concussion syndrome hit on back of head with heavy bag of sand." Claimant described difficulty with word finding, attention, and orientation. The therapist noted that Claimant's attention during the evaluation was appropriate. However, Claimant described difficulty with concentration and attention when reading or watching television in comparison to previous levels. The therapist's assessment was mild cognitive-linguistic deficit characterized by decreased attention and concentration, decreased "SIM", and mild dysnomia. Barriers to learning were listed as a memory impairment, but the therapist gave a favorable prognosis since Claimant was aware of the deficits and was motivated to work toward improvement. Claimant attended speech-language therapy several times per week through April 20, 2001 when his prescription ended.

On November 14, 2000, Claimant returned to Dr. Rehmatullah's office. (CX H). Claimant's hand was reported as doing better, but Claimant's neck was still bothering him. Dr. Rehmatullah advised Claimant to take the splint off of his right hand and to start exercising his right hand.

Claimant presented to Dr. Choi for a discussion on November 16, 2000. After a lengthy discussion with Claimant, Dr. Choi stated that as long as he was improving, he agreed with Claimant's treatment plan and recommended that Claimant continue to treat with the doctors he was seeing.

Claimant was examined by Amy Clunn, M.D. on November 30, 2000. (CX E). Dr. Clunn noted that Claimant was finished with physical therapy and speech therapy. Claimant complained of his neck aching at the base, as well as headaches once or twice a week. Dr. Clunn's assessment was that Claimant suffered from a cervical sprain/strain and a closed head injury. Her plan consisted of prescribing Pamilor, continuing physical therapy and speech therapy, theracane, and the consideration of Zoloft or Effexor. Claimant also received three injections to his cervical spine. Claimant called Dr. Clunn's office and reported an episode of receptive aphasia and dizziness. Dr. Clunn instructed Claimant to present to the emergency room because his symptoms could not automatically be related to his mild head injury months ago.

On December 5, 2000, Claimant was admitted to the Ashatabula County Medical Center with complaints of sudden onset of dizziness and general weakness that lasted a few seconds. (CX J). He was admitted by Dr. Choi. Claimant reported that the headaches he had suffered from since the accident had gotten better. He also stated that his wrist was improving. Dr. Choi stated that an EKG showed right bundle branch block and left bypass color black. Claimant was noted to have a history of hypertension, mild hyperlipidemia, and mild diabetes mellitus. Dr. Choi detected focal weakness. His impression was near syncopal episode, hypertension, hyperlipidemia by history, and history of head injury with headache. Dr. Aygun Nafi interpreted a CT scan of Claimant's brain obtained on December 5, 2000 as normal. Dr. Cho evaluated Claimant on December 5, 2000 also. He interpreted an EKG as showing abnormal left axis deviation and complete right bundle branch block. Dr. Cho's impression was presyncope of unknown etiology, and hypertension. He agreed with the telemetry and opined that Claimant could have cardiac arrhythmia, bradyarrhythmia. Claimant underwent an MRI of the brain on

December 6, 2000 at the Ashatabula County Medical Center due to symptoms of near syncope. (CX E). The results of the MRI were compared with the MRI from October 14, 2000. Dr. Kalliopi Petropoulo's impression of the MRI was that the brain was within normal limits. Dr. James Cho conducted an echocardiography report on December 7, 2000. He opined that the report was a technically suboptimal echocardiograph because of body habitus. Overall, Dr. Cho opined that the report was normal. Dr. Choi discharged Claimant on December 7, 2000 in stable condition, but he noted that further follow-up was necessary. His discharge diagnoses were near syncopal episode, hypertension, hyperlipidemia by history, and history of head injury with headache.

Dr. Choi examined Claimant with December 11, 2000 and agreed with Dr. Cho's recommendation that Claimant undergo a stress test the following Wednesday. (CX E). Dr. Cho conducted a stress test on December 14, 2000. (CX E). He concluded that it was a negative stress test echocardiography for myocardial ischemia with attainment of 98% of age predicted maximal heart rate with a workload equivalent to 9.0 METS. On the basis of the negative stress test, Dr. Cho commented that there was a low probability of severe obstructive coronary artery disease. Dr. Rehmatullah also examined Claimant on December 11, 2000. (CX H). Claimant's was noted to be doing well and his wrist was reported as healing well. Dr. Rehmatullah allowed Claimant more activity with his wrist. He noted that Claimant was still being treated for his neck, etc., and he stated that Claimant was off work.

Dr. Clunn examined Claimant on December 28, 2000. (CX E). She noted that Claimant was still going to physical and speech therapy, but that he didn't get the theracane yet. Claimant still complains of head aches in the amount of two per week. He reported that the previous injections helped for about a week and that the Pamilor also helped. Dr. Clunn's assessment was that Claimant had a cervical sprain/strain. She recommended that he continue the speech and physical therapy, undergo an orthopedic and neurologic consultation. Dr. Clunn issued a prescription to refill Claimant's Darvocet, Motrin, and Pamilor. She stated that Claimant should get a theracane and follow-up in a week.

Dr. Seeds conducted a neurological consultative examination on January 4, 2001. (CX E). He reviewed x-rays of Claimant's wrist and found that they revealed degenerative changes of the distal radius with SLAC wrist, showing collapse secondary to scapholunate disruption. Dr. Seeds noted what appeared to be an old fracture and some cystic changes of the distal ulna, which appears to have good sclerotic borders. Claimant complained of difficulty holding, swelling, occasional aches. Dr. Seed's recommendation is that Claimant undergo wrist fusion to decrease his pain. Dr. Seed's also informed Claimant that he would provide a referral to a hand specialist.

On January 17, 2001, Claimant underwent a carotid duplex study. The report was completed by Walid Massarweh, M.D., whose impression was that there was no evidence of a hemodynamically significant stenosis of the right or left internal carotid arteries.

Claimant presented to Dr. Rehmatullah's office on January 22, 2001. (CX H). Dr. Rehmatullah documented continued discomfort in Claimant's head and neck, as well as numbness in the right side of his face and scalp. Claimant still reported pain in his right hand if

he twists it or uses it to lift. Dr. Rehmatullah recommended symptomatic care. However, once Claimant's head and neck problems are resolved, he will re-evaluate his right hand to see what needs to be done.

Claimant presented Dr. Clunn again on January 25, 2001. (CX E). He reported that he was doing better, but still experienced numbness off-and-on in the right side of his head and twitching in his right eye. Claimant also reported an episode of feeling dizzy, as well as an episode of hearing a crack at the base of his neck when he turned his head that was followed by an electrical shock feeling. Dr. Clunn's assessment was a cervical sprain/strain and post-concussion syndrome since Claimant was still symptomatic. If Claimant's cognition didn't improve by the next visit, Dr. Clunn would request a neurologic consult. She refilled Claimant's prescription for Motrin and set up a consultation with Dr. Lubahn for Claimant's wrist. However, Claimant did not want to see Dr. Lubahn since he was treating with Dr. Rehmatullah, so Dr. Clunn cancelled the consultation. Dr. Clunn's office scheduled an EEG for February 15, 2001. Dr. Walid performed the EEG on February 15, 2001, and found it to be a normal, mostly awake EEK without any clear focal or epileptiform activity.

Claimant returned to Dr. Clunn on March 1, 2001. He reported that he was still going to speech therapy and that he had finished with physical therapy. Claimant stated that he experienced and episode of numbness on February 18, 2001. He continued to complain of headaches. Dr. Clunn examined Claimant and noted that his recent EEG was normal. Dr. Clunn's assessment continued to be cervical sprain/strain and wrist fracture. She noted that Claimant's physical therapy plateaued. Dr. Clunn recommended that Claimant follow-up with Dr. Rehmatullah. Dr. Clunn refilled Claimant's prescription for Pamilor and offered to refer Claimant to a headache specialist.

On March 5, 2001, Claimant returned to Dr. Rehmatullah's office. (CX H). Claimant's wrist was the same, and Dr. Rehmatullah stated that Claimant will need fusion. However, he recommended that Claimant finish with his neurologic work-up and treatment before evaluating the fusion. Claimant complained of brain seizures, electrical shock and numbness around his face. Claimant reported that he was going to see Dr. Lyons for this. Dr. Rehmatullah noted that Claimant's right hand showed mild swelling over the dorsoradial aspect. Claimant reported moderate discomfort on palpation to that area.

The therapist discharged Claimant from physical therapy on March 5, 2001 after Claimant attended thirty-one of thirty-five scheduled visits. (CX F). The therapist noted that Claimant had been discharged by his physician following a visit on March 1, 2001. The therapist referred to a progress note from Claimant's last visit on February 22, 2001. Claimant's overall progress was noted to be good/fair. He achieved 75% of his goals and his progress plateaued. Claimant's current problems were noted to be intermittent cervical spine stiffness, limited cervical spine range of motion, and decreased endurance.

Claimant presented to Dorothy Lyons, M.D. on March 22, 2001. (CX K; EX 2). She documented an accurate account of Claimant's work related injury and related symptoms. Dr. Lyons noted that Claimant had been prescribed Zestoretic, Inderol, Darvocet, Motrin, Cardura, and Nortriptoline, but Claimant felt that these were not helping his head or neck pain. Dr. Lyons

also noted that Claimant had had two MRIs and two brain CT scans, a cervical spine CT scan, an MRA, and an MRI of the neck, all of which were essentially negative except for the herniated disc at C5-6 revealed by the MRI of the neck. Upon physical examination, Dr. Lyons detected no tenderness over the head or neck. Her impression was cervical strain, post concussive syndrome, and spells of numbness. Dr. Lyons' plan was to obtain records from ACMC, and she noted that Claimant may need a two hour sleep deprived EEG.

Claimant presented to Dr. Rehmatullah on April 16, 2001. (CX H). Claimant continued to report quite a bit of pain in his wrist. There was still moderate swelling over the dorsoradial aspect and over the anatomical snuff box. Claimant was still under the care of Dr. Lyons. Dr. Rehmatullah continued to recommend symptomatic care and he prescribed Vioxx.

Dr. Clunn examined Claimant again on April 23, 2001. (CX E). Claimant reported that he had finished speech therapy. He still complained of numbness in his lip that lasts for a few minutes at a time, as well as numbness in his right fingers. He still experienced numbness and tingling in the right side of his head. Claimant still reported significant problems with memory, attention, and concentration. Dr. Clunn's assessment was that Claimant had multiple problems, and she recommended and EMG and neurological testing with Dr. Lyons. She also spoke to Nanette Crawford to arrange neuropsychological speech testing. Dr. Clunn also scheduled an appointment with Claimant to see Dr. Lubahn for his wrist.

Claimant presented to Dr. Lyons on April 24, 2001. (CX K; EX 2). She stated that an EEG was done in the awake, drowsy, and light sleep stages. Claimant was sleep deprived prior to the study and a two-hour study was performed. Her impression was a normal EEG.

Claimant presented to Dr. Lyons for a follow-up visit on May 10, 2001. (CX K; EX 2). Claimant complained of numbness of the lower limb on-and-off during the day, wrist pain, neck pain, fatigue, and headaches. She advised him to take a full aspirin instead of a baby aspirin. Dr. Lyons noted that Claimant's EEG was normal. She believes that Claimant is having post concussive syndrome, which she stated was somewhat improved. Dr. Lyons referred Claimant to a neuropscychologist for further evaluation on May 30, 2001.

On May 21, 2001, Claimant returned to Dr. Rehmatullah's office. He noted that Claimant had been seen by Dr. Lyons and was improving with regard to his headaches. Claimant reported that he was to undergo further testing with Dr. Lyons. Dr. Rehmatullah found Claimant's right wrist to be about the same with pain and swelling over the dorsoradial aspect and the anatomical snuff box. He still advised symptomatic care and to continue the Vioxx prescription.

Dr. Lyons conducted an EMG study on May 22, 2001. (CX K; EX 2). She stated that nerve conduction studies were performed on the right upper extremity, which were normal except for a prolonged median palmar response. Dr. Lyons noted that Teflon coated concentric needle electrodes were inserted into the muscles listed in the right upper extremity. She noted that the insertional activity and recruitment patterns were normal. She detected no fibrillations, fasiculations, or positive waves. Claimant's motor unit potentials under voluntary control were

normal. Dr. Lyons impression was right median neuropathy at or distal to the wrist of mild severity.

On May 29, 2001, Claimant returned to Dr. Clunn after undergoing and EMG RUE. Claimant complained of numbness in his right fingers and on his lips. He also experienced a dizzy session on April 27, 2001 with numbness on the right side of his head. Claimant continued to report right hand numbness, but he did not report headaches. Dr. Clunn noted that Dr. Lyons had no additional input. Dr. Clunn's assessment was right wrist fracture and mild CTS. Dr. Clunn was awaiting the results of Claimant's neuropsychological testing and his appointment with Dr. Lubahn. After being notified by Dr. Schwabenbauer that Claimant might benefit from an anti-depressant, Dr. Clunn prescribed Zoloft on May 31, 2001.

Claimant presented to Dr. Choi on June 28, 2001 complaining of unusual symptoms with cold sweat. Dr. Choi noted that Claimant had been prescribed Zoloft one month ago. Claimant stated that he is not depressed anymore and desired to stop taking Zoloft. Dr. Choi decided to discontinue the Zoloft prescription and advised Claimant to follow-up if his symptoms persist.

On July 9, 2001, Claimant returned to Dr. Rehmatullah's office for a follow-up visit. (CX H). He found Claimant to be doing about the same. Claimant was scheduled to see Dr. Lubahn on July 17, 2001. Claimant returned on July 19, 2001 for his neck after the physician who had been treating his neck went on sick leave. Dr. Rehmatullah stated that Claimant has arthritis in his neck that was aggravated by the injury. He prescribed Medrol Dose-Pak and advised Claimant to continue his Darvocet.

Upon the referral of Dr. Rehmatullah, Claimant presented to John Lubahn, M.D. on July 17, 2001. (CX H). Dr. Lubahn noted that Claimant was a right-handed pipe fitter who was injured on September 12, 2000 when a sandbag fell on his head and he fell to the ground injuring his right wrist. Dr. Lubahn also noted that Claimant had experienced pain and swelling that had not responded to non-operative management, including a period of casting. In addition to Claimant's wrist injury, Dr. Lubahn stated that Claimant suffered from an associated seizure disorder as well as chronic neck pain. Dr. Lubahn detected a moderate degree of swelling and pain in the wrist, with limited range of motion as well. He measured Claimant's grip strength and pinch strength in both hands. Dr. Lubahn obtained a chest x-ray, which he interpreted as showing a fracture through an osteophyte on the radial side of the wrist. He stated that the wrist shows signs of a so-called SLAC appearance or scapholunate advanced collapse, which he believes relates to an old scapholunate dissociation, probable transcaphoid perilunate dislocation. Due to the extent of Claimant's head and neck injuries, Dr. Lubahn stated that he would still treat Claimant's wrist injury non-operatively. His recommended operative intervention would be a proximal row carpectomy.

Michael Schwabenbauer, Ph.D. issued a narrative report on July 23, 2001. (CX L). He recorded an accurate history of Claimant's September 12, 2000 injury and the subsequent symptoms and treatment. He documented Claimant's prior medical history and noted that Claimant completed the ninth grade and received and honorable discharge from the United States Army after achieving the rank of corporal. Dr. Schwabenbauer documented Claimant's present complaints as numbness on the right side of his head that comes and goes, a gradually improving

neck pain, and emotional fragility. Claimant denied any overt suicidal ideations, but he noted that his injury has had a very significant psychological impact on his life and leads him to frequently ruminate about death. Claimant reported experiencing very limited periods of concentration and frequently forgets things. He reported anxiety over the inability to diagnose the cause of his dizzy spells. Dr. Schwabenbauer recorded complaints of limitations in problem solving, planning, and organization, as well as a notable personality change. From his speech therapy sessions, Claimant has learned to write things down. Dr. Schwabenbauer found that Claimant demonstrated quite adequate reasoning skills throughout the examination, with logical and coherent thought processing. Claimant's mood appeared mildly dysthymic with a restricted range of affect noted. He found Claimant to be quite cautious and mildly suspicious during the examination. He judged Claimant's insight into his current level of cognitive and emotional function as fair. Dr. Schwabenbauer submitted Claimant to numerous objective tests, including intelligence tests, personality inventories, memory scales, an anxiety inventory, and judgment tests.

Dr. Schwabenbauer found that Claimant's overall intellectual resources fell well within the average range. His review of specific index scores revealed a number of significant differences. Claimant's working memory was significantly below verbal comprehension and perceptual organization. Claimant's processing speed was significantly below perceptual organization and verbal comprehension. Claimant's working memory tested at the 5$^{th}$ percentile, while his processing speed was at the 18$^{th}$ percentile. Dr. Schwabenbauer's review of his test results reflects wide variability. Claimant's verbal subtests fell within the average range. His ability to determine essential from nonessential details on a pictorial task placed in the 98$^{th}$ percentile. In contrast, Claimant's arithmetic reasoning and ability to problem solve on novel, nonverbal tasks fell well below expected limits, as well as psychomotor processing speed and formal measures of concentration and attention. Immediate recall of verbal information demonstrated mild compromise, while recall of visual information fell within the average range. There was evidence of mild compromise and numerous intrusions upon acquisition of an extensive word list. Claimant showed moderate compromise on visually mediated perceptual processes. His performance on black design subtest demonstrated rotation, and Claimant committed frequent errors on the visual form discrimination task with several major distortions evident. However, performance on the visual organization task was normal. Claimant's ability to copy a complex visual figure fell below expected limits due to mild distortion. Claimant's performance on receptive and expressive language and performance on complex and fine motor skills were within normal limits. Claimant's personality assessment showed moderate-severe anxiety. Claimant acknowledged feelings of psychological and physiological stress. Dr. Schwabenbauer detected considerable depressive symptomatology. Claimant voiced considerable feelings of helplessness, hopelessness, and being overwhelmed. Claimant's emotional distress affected his general level of concentration.

Dr. Schwabenbauer opined that his review of the pattern of findings, in conjunction with the records he obtained and his clinical interview, demonstrates a mild degree of cognitive dysfunction at this state of Claimant's recovery from his accident. He stated that findings suggest mild compromise of immediate verbal and delayed recall, complex attentional processing, and some elements of visuoperceptual function. Furthermore, Dr. Schwabenbauer opined that Claimant's considerable anxiety and depression serve to exacerbate his current level

of performance. In contrast, Dr. Schwabenbauer found considerable improvement in language and attentional function since the onset since Claimant has seemingly benefited from therapeutic efforts. Claimant continued, however, to experience emotional distress. Dr. Schwabenbauer issued three recommendations in light of his findings: (1) He strongly recommended that individual psychotherapy be initiated with a focus on cognitive and emotional residuals following the head injury, which he believed to be an excellent follow-up to Claimant's speech therapy sessions; (2) Provide Claimant with a support group such as the Erie County Brain Injury support group; and (3) Obtain a follow-up neuropsychological assessment in the 9-12 months after his opinion to compare with these baseline findings. Dr. Schwabenbauer expected to see slow, steady improvement over the next 9-12 months after his opinion in Claimant's cognitive function if treatment was ongoing.

On August 8, 2001, Claimant returned for a follow-up visit with Dr. Lyons. (CX K; EX 2). She noted that he has not had any additional speech therapy. Claimant reported a slight improvement in his reading and memory, but he was still having headaches on the right side with weakness, nausea and vomiting. Claimant also reported wrist pain and neck pain. He stated that the numbness in his lip was gone, but he did have some tremors of the right hand. On examination, Dr. Lyons stated that Claimant had some difficulty with short term memory problems and attention. She referred Claimant back to therapy for those problems in the form of outpatient psychometrics.

Claimant returned to Dr. Rehmatullah's office on August 20, 2001. (CX H). He noted that Claimant had resumed speech therapy. Claimant complained of continued problems with his neck with moderate crepitus on range of motion. Claimant still had pain in his wrist, also. Dr. Rehmatullah continued to recommend symptomatic care until Claimant's neck and head problems resolve, and he refilled Claimant's prescription for Darvocet.

Following her August 2001 examination of Claimant, Dr. Lyons answered questions posed to her in a letter sent by Judith Meals, Employer's case manager. (CX K). Dr. Lyons answered that she is not recommending any other testing other than speech therapy, which the family feels is a significant part of Claimant's improvement. She stated that continued cognitive therapy is still necessary and is used frequently, especially in combination with speech therapy. Dr. Lyons wrote that this therapy helps the patient determine the degree of short term memory loss and attention abnormalities. Dr. Lyons could not determine any medical contraindication for proceeding with the proposes surgical fusion of Claimant's right wrist, but she stated that she plans to re-evaluate Claimant in November 2001 to see what additional treatment he needs. Dr. Lyons opined that it is possible that Claimant will have significant attention span abnormalities that would limit him in his day-to-day working environment, which includes short term memory loss, immediate recall, attention, and confusion.

Dr. Lyons provided a prescription for Claimant to return to Nanette Crawford to resume treatment for closed head injury and cognitive dysfunction. (CX G). Therapist Crawford conducted another initial speech-language pathology consultation on August 13, 2001. (CX G). Claimant was noted to have sustained a "TBI" on "9/00", after which he experienced cognitive-linguistic deficits. Claimant's hearing and short term memory were marked as impaired. Therapist Crawford noted that Claimant cannot always form goal directed behavior, but he

knows limitations and effect of his injury. Therapist Crawford commented that Claimant was well aware of his limitations and change in life style since his injury. Claimant was documented as having difficulty with attention, concentration, memory, and goal setting. Therapist Crawford noted that Claimant's complex ideation needed to be evaluated, but his comprehension for social conversation was intact. Her impressions were mild-moderate cognitive-linguistic deficit due to TBI, which interferes with daily living skills. Claimant's decreased memory was noted to be a barrier to learning, but he can compensate with a day planner and he is motivated and actively participates in his therapy. Therapist Crawford noted that Claimant's therapy had been put on hold in April 2001 until Claimant underwent testing and evaluation by Dr. Schwabenbauer. Claimant still reported that he has a problem with concentration, attention, and losing his train of thought when he is distracted.

Claimant returned to Dr. Choi on September 5, 2001 to discuss the numbness of his lips. (CX E). He reported continued problems with his neck and some numbness. Dr. Choi opined that Claimant's lip problem was probably related to his cervical strain and not related to a circulatory problem. Dr. Choir recommended that he continue his current medication.

Claimant returned to the Ashatabula County Medical Center Physical Therapy and Sports Medicine Center on September 10, 2001 for an initial physical therapy evaluation. (CX F). Claimant reported that he had been through physical therapy previously and that it had helped control his symptoms related to his September 12, 2000 accident, but his symptoms returned and were aggravated since ending physical therapy. He complained of cervical spine pain and stiffness that is constant with severe symptoms that come and go. Claimant had no upper extremity complaints. He rated his constant pain as a "5," but added that it was an "8" when it was aggravated. The therapist discharged Claimant from therapy on November 8, 2001 after Claimant attended nineteen of the twenty scheduled visits. The therapist noted that Claimant had met the majority of his goals. Claimant demonstrated improvement with decreased cervical spine range of motion. Claimant stated that he had decreased cervical spine pain and stiffness complaints and decreased tenderness to palpation. The therapist noted that Claimant's progress had plateaued, which was the reason for the discharge.

Claimant presented to Dr. Rehmatullah's office on September 24, 2001. (CX H). Claimant reported that he is doing better. Dr. Rehmatullah noted that therapy helped loosen Claimant's neck. He advised Claimant to continue with Darvocet.

On October 18, 2001, Claimant presented to Dr. Rehmatullah for a follow-up visit. (CX H). He noted that Claimant had had eleven treatments and his neck was feeling better. However, Claimant still reported some tingling in the right side of his face. Claimant's wrist continued to bother him, especially on twisting motion, for which Dr. Rehmatullah recommended that Claimant continue with a wrist splint. He prescribed Vioxx and Darvocet for Claimant, and had Claimant continue with therapy three times a week for another three weeks.

Claimant returned to Dr. Rehmatullah's office on November 19, 2001. (CX H). Claimant was still in therapy for his neck. Neurologically Claimant appears to be intact, but he still has a burning feeling on the right side of his neck with numbness in the right side of his face. Dr. Rehmatullah recommended that Claimant continue with therapy. Depending on his

willingness, he could see Dr. Lubahn again. Dr. Rehmatullah continued Claimant's Vioxx and Darvocet prescriptions.

On December 10, 2001, Dr. Rehmatullah authored a letter to counsel for Claimant. (CX H). He stated that Claimant had been under his care since the September 12, 2000 work-related injury. Dr. Rehmatullah stated that Claimant initially had memory loss and slow speech due to the head injury, but conservative care has resolved these symptoms considerably. He opined that Claimant's neck symptoms appear to be related to an aggravation of a pre-existing cervical spondylosis, which has also responded well to treatment that included physical therapy. Dr. Rehmatullah found that Claimant's right wrist injury was due to an aggravation of an old navicular fracture. He stated that Claimant's right wrist continues to be symptomatic. Based on his evaluation, Dr. Rehmatullah opined that Claimant has reached maximum medical improvement with regards to his head and neck injury. He noted that they will remain mildly symptomatic with some discomfort in the neck and somewhat slower speech than he had prior to the September 12, 2000 injury. He also stated that Claimant will need right wrist surgery, which might involve fusion of the right wrist. Dr. Rehmatullah recommended that Claimant see Dr. Lubahn again.

On December 12, 2001, Claimant presented to Dr. Lyons for a follow-up visit. (CX K; EX 2). Claimant still reported difficulty with his train of thought, immediate recall, and verbal expression. His immediate recall was noted as being somewhat better. Claimant still reported tingling behind the right ear and light bothers his eyes. Claimant stated that he fatigues easily. Overall, Dr. Lyons found that Claimant appeared to be better, even though Claimant appeared somewhat depressed. She believes it to have been a reactive depression, but she did think that Claimant's memory problems may improve if his depression was treated. Dr. Lyons recommended Depakote or Lamictal to treat Claimant's depression.

On January 4, 2002, Claimant returned to Dr. Choi with complaints of a chronic headache and depressive symptoms. Dr. Choi prescribed Elavil for Claimant's depressive symptoms. Claimant returned to Dr. Choi's office on February 4, 2002 because he was having difficulty with his Elavil prescription. Dr. Choi changed Claimant's prescription to Doxepin. One month later, on March 4, 2002, Claimant returned to Dr. Choi's office, having lost twenty pounds recently. Dr. Choi's impression was that Claimant had well controlled hypertension and chronic neck pain. Dr. Choi stopped the Doxepin because Claimant was not tolerating it well and continued to lose weight.

Claimant presented to Dr. Rehmatullah on January 7, 2002. (CX H). Claimant reported that his neck was doing better. He was scheduled to see Dr. Lubahn on January 15, 2002 for his hand. Dr. Rehmatullah recommended that Claimant continue with gentle exercises and use Darvocet for the pain. Claimant followed-up with Dr. Rehmatullah on February 20, 2002. (CX H). Claimant reported that he was doing better. Dr. Rehmatullah noted that Dr. Lubahn feels that Claimant does not need surgery at this point. Symptomatic care was advised. Dr. Rehmatullah stated that Claimant will finish up with therapy and take Darvocet.

On January 15, 2002, Dr. Lubahn issued a narrative report after conducting a follow-up examination of Claimant for a scapho-navicular advanced collapse in his right wrist. (CX M).

He noted that Claimant's symptoms had stabilized somewhat since he saw Claimant last July. Claimant still reported pain in his wrist when using a hammer or screwdriver. Dr. Lubahn noted that Claimant's seizures from his head injury had diminished. Depending on how Claimant fared over the next four-to-six months, Dr. Lubahn was going to consider operative intervention in the form of a proximal row carpectomy. He noted that Claimant's grip strength remained diminished. However, Dr. Lubahn found that Claimant's general range of motion seemed satisfactory.

On February 19, 2002, Dr. Lubahn responded to a letter addressed to him by Employer's case manager concerning whether Claimant was scheduled to undergo surgery. (CX M; EX 1). He opined that Claimant sustained a ligament injury to the scapholunate interosseous ligament and also a probable fracture through an osteophyte in a pre-existing osteoarthritic right wrist. As a result of the injury, Claimant has limited strength and motion in his right wrist. Dr. Lubahn stated that the reason for delaying surgery is that injuries such as Claimant's often heal to the point that operative intervention is not necessary. The potential for healing combined with Claimant's extensive head injury led him to engage in the most conservative approach as possible. After he reviewed Claimant's overall condition, including his combination of head and wrist injuries, Dr. Lubahn stated he was skeptical that Claimant would ever work again as a pipe fitter. He stated that if the wrist injury were isolated, he would be more optimistic. Regarding function, Dr. Lubahn stated that the proximal row carpectomy procedure should relieve Claimant's current level of pain and may add some additional range of motion and strength to his wrist. He stated that the average length of recovery is six-to-twelve weeks.

Dr. Lubahn responded to a follow-up letter from Employer's case manager through a letter dated March 14, 2002. (CX M; EX 1). He stated that he believed that Claimant still has disability secondary to his right wrist injury suffered on September 12, 2000. Dr. Lubahn again re-described the injury and stated that his wrist has shown signs of limited motion with stress, some instability, and significant loss of grip strength on the right. He noted that, while Claimant has shown some improvement, Dr. Lubahn stated that he was still skeptical that Claimant could resume working at his original job. He again stated that the rationale for delaying the surgery is that he believed that Claimant may regain function in his right wrist without the surgery. Dr. Lubahn added that, while Dr. Lyons has no objection to the surgery, if Claimant is not placing any heavy demands on his wrist and doesn't return to his original job, he may be able to continue to function reasonably well without additional operative intervention. He added that the proximal row carpectomy would relieve some of his discomfort and probably add some grip strength, it will by no means restore his wrist to normal. Dr. Lubahn said that the main indicator for surgical intervention is to relieve pain, not to restore function. He opined, should Claimant undergo the surgical procedure, he could conceivably resume a lighter type duty work six weeks after surgery with the resumption of normal duty from the standpoint of his hand in twelve weeks. However, Dr. Lubahn stated that it was his understanding that Claimant's other injuries would prevent him from resuming his normal duties.

After returning to speech-language pathology therapy in September 2001, Claimant attended sessions twice weekly until he was discharged on March 22, 2002. (CX G). Therapist Crawford noted that Claimant's long term goal of increasing attention to 90% accuracy was partially met. She commented that Claimant works best in a quiet environment. He is easily

distracted by noise, but he is able to work through others having a conversation. He has difficulty with alternating/dividing attention. Therapist Crawford marked that Claimant met his long term goal of increasing memory for everyday tasks to 90% accuracy. She commented that Claimant meets this goal as long as he utilizes his day planner. If Claimant does not write information down in an accessible place, he would be likely to forget. Therapist Crawford stated that Claimant partially met his long term goal to demonstrate new learning with 90% accuracy. She commented that this is met with modified instructions and repetitions. Claimant relies upon modified instructions. His reading comprehension ranges between 30% to 90% accuracy. Therapist Crawford instructed Claimant to contact his case manage if he regresses in any manner regarding cognitive-linguistic function.

Claimant presented to Dr. Rehmatullah on March 25, 2002 for a follow-up visit. He noted that Claimant was doing about the same. Claimant was to undergo a functional capacity evaluation, but it was cancelled. Dr. Rehmatullah continued to advise symptomatic care. He stated that Claimant remains disabled from work. He prescribed Darvocet.

Claimant submitted to an independent medical examination by Victoria Langa, M.D. on April 26, 2002. (EX 3). She noted that Claimant was a right-handed pipe fitter who injured his right wrist on September 12, 2000. Claimant could not recall how he injured his right wrist that day, but he reported experiencing pain in his right wrist upon regaining consciousness after the fall and he denied any previous history of injury or pain in his right wrist. Dr. Langa reviewed and summarized the medical treatment that Claimant had received for his right wrist to the time of her examination, including Dr. Lubahn's diagnosis and surgical recommendation. Claimant reported that he had not returned to work, adding that all of his residual complaints have kept him from returning to work. He stated that his right wrist alone would prevent him from performing his regular job duties.

Dr. Langa recorded Claimant's current symptoms as primarily discomfort of his dorsal/radial right wrist associated with some more minor volar/radial wrist discomfort. Claimant described developing aching wrist discomfort with any use. He described some degree of improvement following the injury leading to a plateau in his progress, which left him with residual wrist pain. Claimant also reported developing swelling on occasion and using a splint intermittently. Upon physical examination, Dr. Langa did not detect any swelling, color or temperature changes suggestive of reflex sympathetic dystrophy. She found no problem and full range of motion in Claimant's right elbow. Claimant complained of maximal localized tenderness over the dorsal radial aspect of his right wrist with some more minimal discomfort over the volar/radial aspect. Claimant displayed full ulnar deviation. Dr. Langa also conducted grip strength testing. She noted that the x-rays Claimant underwent on the day of injury revealed a SLAC wrist with evidence of old scaphoid trauma, an old scapholunate dissociation, and significant post-traumatic degenerative joint disease with particularly severe narrowing of the radioscaphoid articulation. In her overall opinion, Dr. Langa opined that at some point in the distant past, Claimant suffered an occult injury of his right wrist that he was not aware of at the time. She stated that it is not unusual for occult injuries in the location of Claimant's injury, and it is especially not unusual for a person Claimant's age to present with recent onset of wrist discomfort leading to a diagnosis of SLAC wrist with long-standing post-traumatic degenerative joint disease. Dr. Langa opined that Claimant's September 12, 2000 work injury caused

Claimant's pre-existing SLAC injury to become significantly symptomatic. She added that purely conservative methods are usually unsuccessful in returning a symptomatic SLAC injury to the preinjury asymptomatic state, noting that a vast majority of SLAC injuries eventually receive surgical intervention.

Dr. Langa opined that Claimant would be a candidate for surgical intervention. She noted that there are two options: (1) fusion, with the major advantage of most reliably relieving symptoms of discomfort and major disadvantage of the loss of all wrist movement; and (2) proximal row carpectomy, with the major advantage of preserving some wrist motion and the principal disadvantage of less reliably relief of discomfort. She found that Claimant would be a suitable candidate for either surgery, but Claimant reported that his symptoms do not bother him enough to proceed with surgery. Since Claimant's symptoms do not bother him enough to warrant proceeding with surgery, Dr. Langa opined that Claimant had long since reached maximum medical improvement. She found that his condition was medically stable, although the natural course of a SLAC wrist with post-traumatic degenerative joint disease is that the degenerative changes will slowly progress over time. Thus, she stated that it is not inconceivable that Claimant may eventually require surgical intervention. Absent surgery, Dr. Langa recommended that Claimant continue with the use of his wrist splint as needed, as well as the use of anti-inflammatory medication. If Claimant were to undergo surgery, she stated that there would be a minimum post-operative recovery of at least six months following either of the surgeries. Absent surgery, Dr. Langa does not see Claimant ever returning to his position as a pipe fitter. With surgery, Dr. Langa opined that there is a reasonable chance, given an uncomplicated post-operative course, that Claimant would eventually be able to return to his position as a pipe fitter. However, she stated that, regardless of what surgery he undergoes, there is not guarantee that he could return to strenuous work activities. Dr. Langa added that both surgeries result in residual diminished grip strength. Given Claimant's current state, she opined that Claimant is physically capable of performing light-duty work activities to light/medium work activities that do not require repetitive use of his right wrist.

Dr. Langa also completed a physical capabilities form. She did not impose any restrictions on Claimant's ability to stand, sit, or walk. She limited Claimant's driving to 1-3 hours in an eight-hour work day. Over an eight-hour work day, Dr. Langa opined that Claimant could perform sedentary work to medium work limited to frequently carrying or lifting twenty-five pounds. She marked that Claimant was able to bend, squat, climb stairs, reach above shoulder, kneel, and use his feet on controls on a continuous basis (67-100%). Dr. Langa found that Claimant could not use his right hand for simple grasping, pushing/pulling, or fine manipulation, and she found that he could use his left hand for simple grasping, pushing/pulling, and for fine manipulation. She did not comment on whether Claimant could work an eight-hour day. Dr. Langa wrote that Claimant may use his right wrist and hand occasionally, and recommended that he use his splint as needed.

On May 8, 2002, Claimant returned to Dr. Lyons. (CX K; EX 2). Claimant complained of intermittent numbness of the lips and scalp, which are not associated with any other symptoms and are not associated with headaches. Claimant also complained of neck pain, for which he takes Darvocet and Motrin, as well as for headaches. Dr. Lyons noted that Claimant may not need wrist surgery if his symptoms, such as the resolution of the freezing of his wrist, continue to

progress. Claimant's speech therapies were completed and Claimant was relatively stable. At the time of the report, Dr. Lyons opined that Claimant has no limitations on his physical capabilities, but she was unable to comment on his cognitive limitations without a neuropsychological re-evaluation and report. Therefore, she stated that she was unable to release Claimant due to his cognitive limitations, and she referred him for vocational rehabilitation.

On May 13, 2002, Claimant returned to Dr. Rehmatullah's office. He noted that Claimant was "holding his own." Claimant reported having good days and bad days. He also reported tenderness on both sides of his neck. Dr. Rehmatullah noted that Claimant's overhead mobility is complete and that his wrist is mildly symptomatic. He advised Claimant to continue with Darvocet. Claimant presented for a follow-up visit on July 15, 2002. (CX H). Claimant reported discomfort in his neck and numbness in the back of his head and right side of his face. Overall, Dr. Rehmatullah stated that Claimant looks stable. Claimant stated that his wrist bothers him if he uses it. Clinically, Claimant is tender in the right side of the neck and right trapezius. He has mild swelling of the right wrist. Neurologically Claimant was intact. Dr. Rehmatullah continued Claimant on Darvocet and advised him that he can use heat modalities on his neck.

Dr. Langa created an addendum to her April 26, 2003 independent medical examination to respond to inquiries received from Employer's case manager. (EX 3). Dr. Langa stated that she consulted the AMA Guide to the Evaluation of Permanent Impairment, 5th Edition, in calculating Claimant's level of impairment. Based on her April 26, 2002 evaluation, but without having Claimant's x-rays, she would estimate a moderate carpal instability pattern equal to a 16% permanent partial impairment of the upper extremity. She added that Claimant's wrist range of motion impairments total to an 8% permanent partial impairment of the upper extremity. Combining the two impairment values, Dr. Langa found that that they result "in a 23% permanent partial impairment of the upper extremity." Dr. Langa stated that the permanent partial impairment rating following fusion or proximal row carpectomy would have to be performed after such surgery depending on the actual results of the surgery. She did state that the AMA guidelines assign a 12% permanent partial impairment of the upper extremity simply relating to a proximal row carpectomy, which would then be combined with range of motion deficit and motor or sensory changes in the hand, if any. In the case of fusion, the loss of motion in the wrist alone would result in a 30% permanent partial impairment rating, which would be in addition to any motor or sensory changes, if any, following the fusion.

On August 20, 2002, Dr. Rehmatullah completed a U.S. Department of Labor Work Restriction Evaluation form. (CX H). Under the heading of activity type, Dr. Rehmatullah marked that Claimant could sit, stand, and walk for two hours per day. He limited Claimant to lifting, bending, squatting, climbing, kneeling, and twisting for zero hours per day. Dr. Rehmatullah limited Claimant's lifting to 0-10 pounds. He restricted Claimant's hand usage to allow simple grasping, but no pushing and pulling, no fine manipulation, and no reaching above the shoulder. Claimant can use his feet to operate foot controls or for repetitive movement. Claimant cannot operate a car, truck, crane, tractor, or other type of motor vehicle. Dr. Rehmatullah did not impose any cardiac, visual, or hearing limitations. There were no restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dust, fumes or gases. No interpersonal relations were affected because of

neuropsychiatric conditions. Dr. Rehmatullah stated that Claimant cannot work an eight hour day; he limited Claimant to a four hour day. He does not anticipate that the worker will need vocational rehabilitation services such as testing, counseling, training, or placement to return to work. Dr. Rehmatullah marked that Claimant reached maximum improvement on August 20, 2002.

Dr. Schwabenbauer issued a narrative report on August 20, 2002 based on his follow-up neuropsychological assessment as he recommended in July 2001. Dr. Schwabenbauer interviewed Claimant on July 16, 2002 and conducted testing on August 20, 2002. Since his initial assessment in July 2001, Dr. Schwabenbauer noted that Claimant had not returned to work and continued to complain of chronic symptoms, which included numbness on the right side and tingling sensations, wrist, and neck pain. Claimant continued to report impairment in attention and concentration, even though he noticed mild improvement at times. Dr. Schwabenbauer documented personality changes involving episodes of depression, headache, and word finding difficulties. He saw Claimant for two therapy sessions, once in October 2001 and once on December 19, 2001. During those sessions, Claimant reported sensitivity to weather, headache, and limitations in concentration, as well as photosensitivity, difficulty maintaining concentration while driving, and intermittent sleep disturbances. During his July16, 2002 interview, Claimant reported experiencing numbness and tingling with some improvement in his dizziness. He reported being easily fatigued. Dr. Schwabenbauer noted mild improvements in attention and concentration, although Claimant stated difficulty when reading or engaging in more complex tasks. Claimant reported violent dreams producing headaches upon awakening. He also reported symptoms of depression, feelings of hopelessness, and an approximate thirty pound weight loss over the past several months. Dr. Schwabenbauer described Claimant's mood during the interview as mildly dysthymic, with a restricted though pleasant affect in his voice. Claimant continued to demonstrate fair insight into his level of cognitive and emotional function. He found Claimant's though processes to be logical, coherent, and free of any loose associations. Dr. Schwabenbauer did not detect any slowing in information processing or delays in processing events. However, Claimant encountered considerable difficulty concentrating during the assessment. Claimant demonstrated fatigue and limited concentration, which required repetition of instructions. Dr. Schwabenbauer stated that Claimant appeared to be putting forth his best effort at completing the tasks.

Dr. Schwabenbauer administered essentially the same battery of objective testing as he did in July 2001. He set forth the findings of the re-assessment and compared them with the initial findings, noting that considerable variability remained in individual subtest scores. In summary, Dr. Schwabenbauer found that measures of executive function showed little improvement in comparison to the previous assessment, while nonverbal reasoning demonstrated a significant improvement. He concluded that the findings after re-assessment demonstrate mild improvement in some elements of cognitive dysfunction since the prior assessment. He found that the test findings indicate significant improvement in nonverbal reasoning abilities. The findings continue to demonstrate mild compromise of immediate and delayed verbal recall, as well as complex and attentional processing. Claimant continued to experience episodes of depression and anxiety, which exacerbated his cognitive residuals. Claimant's self-report included statements relating to general improvement in attention and concentration, although this area remained problematic as compared with his prior level of function. Overall, Dr.

Schwabenbauer found Claimant's intellectual resources to remain well within the average range. He continued to experience periods of emotional distress, with some improvement since the initial evaluation. Since two years had passed since the date of onset, Dr. Schwabenbauer opined that it is unlikely that further significant gains in cognitive function would be forthcoming. Consequently, he stated that continued development of compensatory strategies would serve to better improve Claimant's day-to-day function. He rendered three recommendations: (1) He thought that Claimant would benefit from individual therapy focusing on anxiety and stress management, since those with similar findings generally improved in their overall level of cognitive and emotional function; (2) He would give further consideration to anti-depressant therapy; and (3) A follow-up of cognitive rehabilitation through approximately three-six sessions.

Claimant returned to Dr. Choi on August 23, 2002 complaining of dizziness, especially in the morning. Dr. Choi's impression was hypertension, maybe possible postural hypotension. He suggested that Claimant stop the Cardura prescription completely and continue with Inderal and Zestoretic. Two months later on October 28, 2002, Claimant returned to Dr. Choi's office. He was complaining of pain in his low back radiating to his right leg. Upon physical examination, Dr. Choi found soreness in Claimant's lower back in the right lower lumbosacral area. He also detected slight limited motion. Dr. Choi's impression was lower back pain with radiating pain to the right leg that was possibly due to lumbar disc disease. He prescribed Ultracet for Claimant's pain and recommended physical therapy. Claimant followed-up with Dr. Choi on November 7, 2002 and reported that he was feeling much better after receiving physical therapy. Claimant reported that his back pain is almost gone. Since Claimant is well-improved, Dr. Choi recommended that Claimant continue to exercise at home and finish up his physical therapy.

On August 23, 2002, Claimant presented to Dr. Rehmatullah for a follow-up visit. (CX H). Claimant reported having a few bad days with some dizzy spells as well. Claimant's neck still bothers him and he was tender in his right side. He suffers dizzy spells when he moves his neck. Overhead mobility of the arms is complete and Claimant is neurologically intact. Claimant had mild swelling of his right wrist with mild aching. He recommended that Claimant continue with symptomatic care, Darvocet, and Motrin.

Claimant returned to Dr. Lyons office on August 26, 2002 for a follow-up visit. (EX 2). Claimant still reported some neck pain and numbness in his lower lip and over the right side of his scalp. She noted that the cause of the symptoms had not been identified. Dr. Lyons documented that Claimant's symptoms had been fading, but now they are more prominent. She reported that Claimant had been prescribed Darvocet, Inderal LA for hypertension, Zestorovic, and aspirin. Dr. Lyons started Claimant on Neurontin for Claimant's sensory symptoms due to their lack of specific cause and increase in severity.

On October 9, 2002, Claimant presented to Dr. Rehmatullah for a follow-up visit. Claimant was seeing a neuropsychiatrist again and is waiting to start therapy again. Claimant reported stiffness in the neck. Dr. Rehmatullah stated that overhead mobility of his arms is complete, and he found Claimant to be neurologically intact. He noted a mild decrease in range of motion with pain. Dr. Rehmatullah advised Claimant to continue with symptomatic care, Darvocet, and Motrin.

Claimant returned to Dr. Rehmatullah on December 9, 2002 for a follow-up visit. (CX H). He noted that Claimant finished with his speech therapy with no significant improvement. Claimant still reported pain in his neck on overhead mobility. Claimant also reported pain in his right wrist and hand. Dr. Rehmatullah recommended symptomatic care and he refilled Claimant's Darvocet and Motrin prescriptions.

Nanette Crawford completed a speech/language evaluation/discharge summary on December 12, 2002. (CX N). Therapist Crawford stated that Claimant was well known to her since she had treated him at the Ashatabula Clinic after his September 12, 2000 injury, where she focused on the development of compensatory strategies for memory management. She noted that Claimant reported that he had a difficult time with memory, such as forgetting where he put items or forgetting to take medication. He currently uses a day planner, which he uses to keep track of his appointments and to make notations. Claimant completed a prospective memory screening, which identified memory failures in the areas of attention/prospective memory, anterograde memory, and retrograde memory. Therapist Crawford's impression was that Claimant suffered from a moderate cognitive linguistic deficit characterized by reduced memory, which interferes with independent living skills and activities of daily living. She found Claimant to be very receptive to intervention suggestions. Claimant's therapy focused on his perceived memory failures and implementation of strategies for those with which he had no efficient strategy in place. Therapist Crawford found that Claimant responded better to memory tasks when there was an external cue. At the time of discharge, therapist Crawford recommended that Claimant: (1) use his learned strategies consistently; (2) obtain an audiological evaluation; (3) practice assertiveness by informing people that information should be directed to him and not solely to his wife; and (4) purchase a digital clock timer.

Following independent neuropsychological evaluations of Claimant on January 13, 2003 and February 2, 2003 at the request of Employer's case manager, Michael McCue, Ph.D. issued a narrative report. (EX 4). He noted that Claimant suffered an industrial accident in which he suffered a head injury when struck by a bag of sand. Claimant reported current problems of "inability to use his left hand, neck pain, lack of strength and stamina, headaches, photosensitivity and cognitive problems including forgetfulness and memory problems, concentration difficulties and word-finding problems." He obtained Claimant's history from a clinical interview with Claimant and a review of medical records, which included the reports of neuropsychological testing conducted by Dr. Schwabenbauer and the raw "NP test data from two administrations by Dr. Schwabenbauer (submitted by Attorney Gregory (sic) Sujeck who represents Mr. Bordeaux)." Dr. McCue summarized the medical records that he reviewed. Dr. McCue documented an accurate account of Claimant's social history. He noted that Claimant complained of an "inability to use his right hand, neck pain, fatigue and lack of strength, frequent headaches and cognitive problems." He noted that Claimant's cognitive problems include memory problems, trouble expressing himself verbally, and losing his train of thought.

During his clinical interview of Claimant, Dr. McCue discovered no evidence of undue anxiety, but he found Claimant's affect to be somewhat dysthymic. He documented Claimant's ambulation as slow and rigid. Dr. McCue detected diminished left auditory acuity with formal sensory-perceptual assessment. He noted that Claimant strained to see at distances, even though

he was wearing glasses. Claimant also required frequent breaks during the day as he became easily fatigued. Dr. McCue found Claimant's conversational speech to be relatively fluent. He noted that Claimant apparently lacked confidence in his ability to follow complex instructions and approached tasks tentatively. He stated that it appeared that Claimant was motivated to perform at his best and put forth a good effort during testing.

Dr. McCue submitted Claimant to a battery of testing and assessments. He documented Claimant's performance on the testing. Upon reviewing the results, Dr. McCue found them to be consistent with the evaluations conducted by Dr. Schwabenbauer with regard to Claimant's cognitive functions. He stated that Claimant continues to experience mild to moderate cognitive limitations in attention and mental control, executive functions involved in planning and self-regulation, and mild memory impairment. Dr. McCue opined that Claimant also appeared to have sensory problems likely related to a peripheral impairment. Additionally, he found that Claimant was also experiencing mild to moderate depressive symptoms that are most likely reflective of adjustment to impairments and pain associated with his injury.

Dr. McCue answered six questions submitted to him by Employer's case manager. First he stated that his diagnoses related to Claimant's work injury include post-concussive disorder and depressive disorder secondary to injury related limitations. He opined that Claimant would benefit from intensive, short-term psychotherapy to address his cognitive limitations, as well as his affective disturbance from a therapist familiar with post-concussive disorder. Dr. McCue also recommended a cognitive-behavioral orientation that is practical and focuses on addressing obstacles to recovery. If Claimant attended regularly, Dr. McCue thought that 12-16 weekly sessions could produce positive results. Dr. McCue recommended additional intervention focused on returning Claimant to work, since cognitive interventions so far had not been focused on returning Claimant to work. He would send Claimant to work hardening because Claimant expressed fatigue and limited endurance. He found that specific vocational interventions would also be necessary to identify the obstacles to employability through accommodations and modifications. Dr. McCue thought that an evaluation for assessing the value of assistive technology would also be beneficial. Dr. McCue stated that psychotherapy should be a priority for 3-4 months, with vocational rehabilitation efforts possibly taking another 3-6 months. He stated that the pattern of Claimant's impairments is not likely to be caused by Claimant's educational level. While Claimant may have some academic limitations, he found those to be separate from Claimant's cognitive impairments. Dr. McCue stated that Claimant's intelligence testing shows that Claimant is reasonably bright, despite having minimal formal schooling and some spelling problems. Dr. McCue opined that Claimant has reached maximum medical improvement, but with treatment, he would expect significant further functional gains. Lastly, Dr. McCue opined that Claimant was not capable of returning to gainful employment at the time of his report.

Dr. Schwabenbauer was deposed on February 4, 2003. (CX S). Dr. Schwabenbauer detailed his background in treating victims of head injuries, including a post-doctoral fellowship at a hospital dedicated solely to treating victims of head injury. His current practice is focused on returning injured persons to the workforce. He reiterated the findings and conclusions contained in his July 23, 2001 report. Dr. Schwabenbauer noted that Claimant's loss of consciousness and post-traumatic amnesia were probative symptoms towards assessing

Claimant's condition. He discussed Claimant's constellation of symptoms. Dr. Schwabenbauer identified and stated the purpose of the objective testing that Claimant underwent. Based on the objective testing, Dr. Schwabenbauer concluded that Claimant sustained a mild degree of cognitive dysfunction, particularly in the area of immediate verbal and delayed recall, more complex attention processing, and some element of visual perceptual function. He found that the tests also demonstrated notable anxiety and depression, which exacerbate Claimant's overall cognitive performance. Dr. Schwabenbauer recounted the numerous performance areas on the objective tests where Claimant showed a decline. When asked how his assessment of Claimant's performance declinations would affect Claimant in the job market, Dr. Schwabenbauer stated that all of the functions would come into play. He noted that attention, memory, and executive function would be particularly important, as well as organizational skills. Dr. Schwabenbauer noted that these skills in Claimant had been affected to enough of a degree that Claimant would fail in a new job setting relying on his cognitive functions as they existed after the head injury. He added that his psychological assessment of Claimant's cognitive function would affect any attempt to return to work.

Dr. Schwabenbauer then reiterated the findings and conclusions contained in his August 20, 2002 follow-up report. After restating the symptoms Claimant complained of at the follow-up examination, Dr. Schwabenbauer characterized Claimant's condition as a fairly consistent picture to what he had seen previously. He stated that the speech pathology and the clinical treatment that Claimant had been receiving were not designed to cure Claimant's memory problems or his attention problems. Rather, the therapy was intended to teach Claimant different methods to compensate for his loss of memory. Dr. Schwabenbauer, during the follow-up examination, noted that he submitted Claimant to essentially the same objective testing as he had during the first examination. Based on the follow-up battery of tests, as with the initial assessment findings, Dr. Schwabenbauer stated that the findings continued to reflect difficulty and significant impairment in terms of immediate and delayed verbal recall, as well as complex attentional processing. Claimant continued to experience episodes of depression and anxiety, although he noted some mild improvement. By and large, Dr. Schwabenbauer found that Claimant's problems with memory, attention, and executive functions persisted. He noted that Claimant's working memory performance actually declined from the initial assessment, falling into the third percentile. Claimant showed improvement in his nonverbal reasoning ability. Claimant continued to show significant problems with problem solving. He opined that Claimant suffered from a significant impairment in his attention, memory, and executive functions that persisted across both tests. Dr. Schwabenbauer found that Claimant had reached maximum medical improvement, adding that most people who suffer head injuries reflect a primary period of recovery of six-to-twelve months. After the primary recovery period, people do continue to improve, but Dr. Schwabenbauer stated that it is very unlikely that any significant functional change will be forthcoming. Thus, he opined that Claimant's difficulties with memory, concentration, attention, and personality disorders are permanent in nature. Then, based on the recommendations he made after his follow-up assessment, he stated that he thought additional individual therapy would be of some benefit to Claimant because of ongoing concerns with depression and anxiety.

Dr. Schwabenbauer opined that Claimant's problems with attention, concentration, and organizational skills would significantly interfere with his ability to return to the workplace. He

elaborated by stating that Claimant's ability to retain information from one setting to the next is impaired, meaning that something he learned on Monday he could forget by Tuesday or Wednesday. Dr. Schwabenbauer stated that Claimant's anxiety and depression have a significant effect on Claimant's cognitive function, and because they are persistent, they will likely further impair Claimant's attention, concentration, and memory functions. Claimant also has an impaired ability to tolerate stress, which would affect his performance on the work site. Dr. Schwabenbauer opined that, if Claimant were to attempt to return to work, Claimant's cognitive limitations would significantly interfere with his ability to perform job. He added that the constellation of Claimant's symptoms would significantly impair his ability to work efficiently and productively on a day-to-day basis.

Upon cross-examination, Dr. Schwabenbauer stated that Claimant's ninth grade educational level would affect his performance on the objective testing, but since he did not have a base level of testing before Claimant's injury, he could not evaluate the overall impact of Claimant's educational level on the results of the testing. Dr. Schwabenbauer noted that Claimant did not perceive a difficulty in performing the same tasks repeatedly after learning them, but he found that objective testing showed that Claimant would have a difficult time learning a new task and showed that Claimant would repeatedly make the same mistake. He opined that Claimant would have difficulty with complex employment and with employment that was somewhat routine because of Claimant's cognitive problems. Dr. Schwabenbauer noted that Claimant did experience pre-existing verbal concerns, which included problems with writing letters or words incorrectly, as well as with written expression. Dr. Schwabenbauer discussed the differences between a mild, moderate, and severe cognitive dysfunction. He stated that a person with a severe cognitive dysfunction would have virtually no ability to process information, so they would have difficulty with alertness, attention, and memory. A moderate dysfunction would leave a person to receive moderate assistance, perhaps institutionalization, to live because their cognitive deficits would require twenty-four hour supervision. A mild dysfunction allows a person to live independently and leaves the person with the ability to participate in most activities of daily living, such as hygiene, grooming, and meal preparation. However, a mild dysfunction causes problems with performing higher level brain functions required in a normal day, difficulty with cognitive endurance, and being easily distracted.

At the time of the deposition, Dr. Schwabenbauer was not aware of whether or not Claimant had been attending individual therapy, nor whether Claimant had been using antidepressants since his last meeting on in August 2002. He noted that Claimant had been attending cognitive rehabilitation therapy, and he added that Claimant showed a dramatic improvement in his nonverbal reasoning skills from the initial testing. Dr. Schwabenbauer characterized nonverbal reasoning skills as the ability to understand how things occur in a sequence or anticipating how one event follows another; nonverbal reasoning would apply to Claimant's ability to follow directions in a task. Dr. Schwabenbauer stated that the antidepressants and individual therapy that he recommended, even though he found Claimant to have reached maximum medical improvement, were to help Claimant with his emotional residuals. He offered that they would not lead to any further cognitive recovery; they would only try to attack Claimant's mental problems. Dr. Schwabenbauer stated that Claimant's emotional problems do affect Claimant's ability to work, and the antidepressants and individual therapy were intended to alleviate or minimize those symptoms, which would have some impact on

Claimant's ability to return to work. He added that it would not be possible to tell how much the therapy would affect Claimant's ability to return to work until he started the therapy. Dr. Schwabenbauer continued to recommend that Claimant undergo individual therapy. He opined that it would be within the realm of possibility to see improvement from antidepressant therapy and individual therapy, but he added that it is very difficult to predict someone's response to treatment in advance. Dr. Schwabenbauer continued to opine that Claimant is excluded from all types of employment. Dr. Schwabenbauer stated that Claimant attended extensive individual therapy sessions with Nanette Crawford, who is skilled in cognitive rehabilitation but not in the treatment of depression. He noted that Claimant had reached a plateau in his level of improvement and that he had reached maximum medical improvement, even though medication and therapy may lead to an improvement or worsening in the future. Dr. Schwabenbauer stated that the bulk of spontaneous recovery from head injuries occur within a year, with most people experiencing maximal return within six months. After a year, the gains that are made are quite limited.

Nanette Crawford was also deposed on February 4, 2003. (CX T). She testified that she was a speech-language pathologist who has worked with head injury patients for eleven years. The goal of her treatment of cognitive linguistic deficits is to return individuals to the workplace. Therapist Crawford treated Claimant in three blocks of sessions, which began on November 6, 2000 and ended with the last session on December 4, 2002. At the outset of her treatment of Claimant, she noted that Claimant appeared to have deficits in attention, concentration, and short term memory, as well as a problem with language function known as dysnomia. Therapist Crawford reiterated her findings and conclusions based on the three blocks of therapy sessions. She stated that her sessions mostly focused on development of compensatory strategies and improvement of attention. She also worked on strategies of adapted directions, because every time a new task was introduced to Claimant, such as the use of a calculator, he would have to be given step-by-step written directions reduced to the simplest format to be able to perform the task. Even for using a calculator, Claimant required a lot of repetition of instructions in succeeding sessions. The chief compensatory strategy that Claimant was taught was the use of a daily planner. Claimant needed to write in the planner any type of detailed information that he wanted to remember from one day to the next, any place that he wanted to go, or any question that he wanted to ask. Claimant was also instructed on the use of an audible timer to remind him to perform a certain task. Therapist Crawford stated that the timer was used to help with Claimant's prospective memory. She would instruct Claimant to do something in ten minutes. When Claimant heard the timer ring in ten minutes, Claimant would have to perform the instructed task. Therapist Crawford stated that Claimant had difficulty with this; he would have to write down in his planner the task that he was supposed to perform in ten minutes sometimes. She noted that Claimant had difficulty with reading, noting that the longest reading session she achieved with Claimant was continuous reading for twenty minutes.

When Claimant was discharged from the second block of sessions in March of 2002, Claimant had partially met his goal of improving attention, but he needed a quiet environment to work in. He was easily distracted by noise. He was able to work through having one other person in the room, but therapist Crawford didn't believe that he could work in a noisy environment. Claimant still had difficulty with alternating divided attention. By the time Claimant returned to therapist Crawford for the third session, Claimant was still having problems

with his memory. Claimant continued to have problems remembering where he placed items, forgetting to pick items up when he went to the store, forgetting what he entered a room for, and forgetting to take his medication. Based on Claimant's situation after the third session was completed, therapist Crawford opined that Claimant would have a difficult time in a work situation unless he was in a completely distraction free environment. Claimant would also need instructions on tasks and possibly a job coach, which would be someone present on the job with him to actually take the requirements of his job and teach him how to most effectively learn the tasks. She added that the job coach would have to be there probably for a long period of time until Claimant learned the tasks. If the requirements of the task changed, the job coach would have to return. Therapist Crawford stated that Claimant's cognitive deficits, after the end of the three sessions, were in the area of attention, concentration, and memory. Upon cross-examination, therapist Crawford discussed the specific events of her treatment sessions and the reasons for the different therapy tasks she employed in relation to Claimant's symptoms.

On February 10, 2003, Claimant returned to Dr. Rehmatullah's office for a follow-up visit. (CX H). Claimant still had tingling at the back of his head, pain in his neck, right shoulder, and down his right arm, as well as limited mobility and clicking in his right wrist. Claimant was clinically tender in the neck and right trapezius. Claimant's wrist showed moderate crepitus on range of motion. Dr. Rehmatullah found mild tenderness in the dorsoradial aspect. He recommended conservative care and advised Claimant to continue with Darvocet and Motrin.

Dr. Rehmatullah was deposed on February 10, 2003. (CX U). He is a board-certified orthopedic and neurologic surgeon. The first time he provided treatment to Claimant was on September 13, 2000 in the emergency room to apply a cast to Claimant's right wrist. Dr. Rehmatullah reiterated the findings and conclusions he reached from Claimant's numerous office visits. He stated that he based the work restriction evaluation form on Claimant's condition as a whole, which included his neck symptoms, wrist problems, and head problems. He testified that the work restrictions he issued on August 20, 2002 would be the work restrictions he would issue at the time of the deposition. He reiterated his finding on August 20, 2002 that Claimant had reached maximum medical improvement. Dr. Rehmatullah opined that Claimant sustained an injury to his right wrist on September 12, 2000 that resulted in a 16% loss of use of the right arm under the AMA guidelines. Given the time Claimant's right wrist symptoms have persisted, Dr. Rehmatullah stated that Claimant's right wrist impairment is permanent in nature. Claimant's future care for his wrist will be symptomatic care; that is all the care for the right wrist that Claimant will need since Claimant will not be able to return to work as a pipe fitter, which led Dr. Lubahn to find that surgical intervention in Claimant's right wrist would only marginally benefit Claimant. He opined that Claimant had pre-existing arthritis in his neck that was aggravated on September 12, 2000 by the falling sandbag. Dr. Rehmatullah opined that Claimant's neck had reached maximum medical improvement as of August 20, 2002. He found that Claimant's neck injury was permanent in nature given the length of time Claimant's neck symptoms had persisted. He added that Claimant may need future care for his neck if his symptoms flare-up, as well as medication.

Regarding Claimant's return to work, Dr. Rehmatullah first noted that Claimant would have difficulty in driving to work anywhere because it would aggravate his neck, noting also that

Claimant's neurologist advised him not to drive too much because of his head condition. At work, Claimant's ability to sit in one position would be impaired because of his neck. With regards to any manual work like lifting, twisting, looking overhead, and using his arms overhead would be impaired because of Claimant's wrist and neck.

Dr. Rehmatullah stated that he knew that Claimant had a prior injury to the navicular bone in his right wrist because the navicular and other carpal bones were collapsed in the x-ray film obtained after Claimant's injury and osteophytes had fractured off during the new injury. He noted that osteophytes are formed when the body reattaches after an injury. Dr. Rehmatullah concluded that the injury on September 12, 2002 caused an old osteophyte to break in addition to ligamentous injury. Dr. Rehmatullah agreed with Dr. Lubahn's diagnosis of SLAC, scapholunate advanced collapse. He stated that the procedure Dr. Lubahn had recommended to treat Claimant's SLAC, a proximal row carpectomy, would involve removing a the entire row of bones closest to the ulnar and radius. After the proximal row carpectomy, Claimant's function would be significantly impaired, because a carpectomy is performed mainly for pain relief.

Dr. Rehmatullah stated that he had been treating Claimant for his wrist and neck. He diagnosed the neck condition caused by his September 12, 2000 accident as an aggravation of pre-existing cervical spondylosis. Dr. Rehmatullah opined that Claimant's cervical spondylosis pre-existed his accident by a few years based on the amount of spondylosis present. He was prescribing Darvocet to alleviate the pain Claimant experienced from his wrist and neck injuries, and he prescribed Vioxx to alleviate inflammation from both of those injuries. Dr. Rehmatullah ruled out Claimant's cervical spondylosis as a cause of Claimant's neurologic complaints and his complaints of tingling and numbness. By 2002, Dr. Rehmatullah acknowledged that Claimant was able to use his arms above his head, but Claimant still had difficulty when titling his head back because he gets dizzy when he tilts his head back.

Rod Durgin, Ph.D. interviewed and tested Claimant on February 18, 2003 and he issued a narrative report on February 28, 2003. (CX V). He noted that Claimant was a 59-year-old semi-skilled worker who completed the eighth grade. Dr. Durgin documented Claimant's work as a pipe fitter apprentice, his military service from 1964-1966, and that Claimant obtained his able seaman's card and wheelsman card. He considered Claimant's various work from 1958 through 1964 as a dock worker and fish cleaner. Dr. Durgin noted the heavy physical demands of Claimant's work from 1967 to 1971 as a seaman and his duties as a general laborer from 1972 to 1981. From 1981 to 1997, Dr. Durgin documented Claimant's work as a welder for various companies. He noted that Claimant began to work for Employer in 1997 as a head pipe fitter. Claimant's work was recorded as skilled in nature and heavy in terms of physical demand. Dr. Durgin noted that Claimant's work also required climbing, crouching, kneeling, reaching, handling, fingering, talking, hearing, and seeing. Dr. Durgin also noted that Claimant worked for Employer until he was injured on September 12, 2000 by a falling sand bag. He documented Claimant's subsequent medical treatment, as well as Claimant's symptoms and complaints. Dr. Durgin documented Claimant's limited range of motion in his neck, which makes it painful to sleep. Claimant reported that his right wrist was also injured and continues to create problems in the form of intermittent pain that is exacerbated by prolonged physical activity involving the wrist. Claimant stated that lifting is a problem that leads him to experience pain even with simple routines, such as lifting a kettle off of the stove. Dr. Durgin documented Claimant's

reports of being unable to lift his wrist up or down, pain on rotation of the wrist, and the need to wear a wrist brace to prevent movement of his wrist. Claimant also reports occasional pain in his right shoulder of an unknown origin. Dr. Durgin also documented Claimant's weekly experiences of headaches, which occur sometimes up to three times per week and are so intense that he is forced to lie down. Claimant reported getting sick from head pain. He also reported a numbness in his head that pulsates, which is in addition to numbness and tingling in his lips. Dr. Durgin noted Claimant's report that concentration is difficult. Claimant stated that staying focused is a problem, and that reading is an arduous multi-tasking problem. Also, Claimant stated that his memory is a problem that requires him to keep notes in order to plan his day.

Dr. Durgin administered an intelligence test to measure Claimant's word recognition and arithmetic achievement, and he administered a peg board test to assess how quickly and accurately Claimant could work with his hands. Dr. Durgin interpreted the intelligence to show that Claimant is average in terms of his reading and arithmetic achievement. He stated that Claimant's scores on the peg board test show that Claimant has no capacity to utilize his dominant right hand in an independent manner and below average capacity to use his left hand in an independent manner. Furthermore, Dr. Durgin found that Claimant had no capacity to utilize both of his hands in a coordinated manner or when assembling small objects.

Before assessing Claimant's present capacity to work, Dr. Durgin reviewed numerous medical records beginning with the rescue squad reports from September 12, 2000 and ending with the depositions of Nanette Crawford, Dr. Schwabenbauer, and Dr. Rehmatullah. He documented the work restrictions given by Dr. Rehmatullah on August 20, 2002. He noted Dr. Schwabenbauer's assessment of a mild cognitive dysfunction that was exacerbated by Claimant's anxiety and depression. Dr. Durgin, based on the information gathered during his interview with Claimant, that as a result of Claimant's injury, his vocational profile is now one of a variety of semi-skilled work that is sedentary in terms of physical demand and requires no more than average intelligence. Additionally, he noted that the work should require no more than a below average degree of manual dexterity, a below average degree of finger dexterity, and a below average degree of concentration. Dr. Durgin stated that Claimant is unable to perform the full range of duties required of him and thus meets the U.S. Department of Commerce definition of having an occupational disability. He stated that there is a limitation in terms of the amount of work Claimant can perform as a result of his physical impairment.

Dr. Durgin characterized an individual's power to earn money as a function of their capacity to work, which is predicated on a series of measurable trait characteristics. In assessing Claimant's post-injury capacity to perform work and earn money, Dr. Durgin conducted a computerized analysis of 12,000 occupational titles contained in the Dictionary of Occupational Titles. He cross-referenced each title by physical demands, working conditions, and the requisite intelligence level. He then cross-referenced each occupational category with the number of workers in the Cleveland, Ohio labor market and the median 1998 national earnings for workers within each occupational category. Dr. Durgin stated that, since Claimant has experienced an extremely narrow scope of tasks during his work life basically only as a pipe fitter and welder, Claimant's acquired work skills are those that are not readily transferable to any other occupation or industry. Dr. Durgin stated that a computerized analysis reveals that work that meets Claimant's vocational profile constitutes 0.19% of the jobs existing in his local labor market. He

noted that jobs that Claimant retains the capacity to perform do not exist in significant numbers in Claimant's local, state, or national economies. Based on Claimant's age, lack of acquisition of transferable skills, physical/exertional limitations, and lack of access to the jobs in his labor market, Dr. Durgin opined that Claimant is competitively unemployable.

Dr. Durgin was deposed on March 12, 2003. (CX V). He testified that he holds a masters degree in vocational counseling, a Ph.D., and additional training in the area of economic assessment of earnings and the economics of personal injury evaluation. Dr. Durgin reiterated the findings he developed from his interview of Claimant and the objective testing that he conducted. He testified that Claimant would be eliminated from any occupation requiring light to heavy labor based solely on Claimant's exertional limitations. Even though some of Claimant's limitations fall below the sedentary level, Dr. Durgin opined that Claimant retained the capacity to perform some level of sedentary work if it was available. Additionally, Dr. Durgin stated that Claimant's cognitive impairments act as another layer of limitation on top of Claimant's physical exertional requirements, limiting more opportunities. He explained the process he undertook to evaluate whether work exists in Claimant's local job market based on Claimant's work history, medical data, his personal evaluation of Claimant, and his objective testing of Claimant. He then reiterated his conclusion that Claimant is not employable based on his age, physical limitations, and lack of transferable skills.

Upon cross-examination, Dr. Durgin stated that Claimant served as an average historian during the interview. He added that Claimant had the typical closed-head affect, which is the classic byproduct of a closed head injury where Claimant's eyes were a little glazed and a tad distant. Dr. Durgin stated that he relied primarily on Dr. Rehmatullah's assessment of Claimant's physical limitations because Dr. Rehmatullah was Claimant's treating physician. He testified that he did not consider the opinions of Drs. Langa and Lubahn with respect to their assessment that a proximal row carpectomy would relieve pain in Claimant's wrist and would provide additional stability and grip strength because he considered their opinions to be vague and noted that Dr. Lubahn stated that a proximal row carpectomy would not return Claimant's wrist to normal. Dr. Durgin stated that Claimant is not employable. Of the 0.19% of positions he identified, he stated that a bulk of them are administrative support positions. Dr. Durgin testified that Claimant is not "going to get the jobs because he's 59 years old and he's a disabled worker trying to get two-tenths of 1 percent of the jobs in his local labor market." Dr. Durgin admitted that he did not identify with specificity the identify of the 0.19% of jobs available to Claimant. Any time jobs exist in a percentage less than 5%, Dr. Durgin finds that jobs do not exist for people to competitively go after.

Dr. Langa was deposed on April 8, 2003. She is board-certified in orthopedic surgery. She reiterated the finding and conclusions contained in her medical reports. Dr. Langa's evaluation of Claimant was limited to his right wrist and hand. She elaborated on the condition of SLAC wrist, which she and Dr. Lubahn diagnosed. Dr. Langa stated that a SLAC wrist (scapholunate advanced collapse) occurs when an initial trauma disrupts the scapholunate ligament, which causes the scaphoid and lunate to lose their normal relationship to one another. The result is a scapholunate dissociation, which is a gapping between the bones. Post-traumatic degenerative and post-traumatic arthritic changes occur at the articulation between the scaphoid and lunate and distal radius. The abnormal relationship between the bones causes abnormal

stress patterns throughout the other carpal bones, which leads to arthritis. The end result of this process is a SLAC wrist. In a SLAC wrist, which is the end-stage of the process, the arthritis has become predominant in causing symptoms. Dr. Langa stated that the x-rays obtained on the date of Claimant's injury show that the changes characteristic of a SLAC wrist existed at the time of the injury. She added that the condition of a SLAC wrist is notorious occultly (unnoticed) with the person not even recognizing they suffered a significant injury. She opined that Claimant's work injury on September 12, 2000 caused Claimant's asymptomatic SLAC wrist to become symptomatic. However, she did not think that the September 12, 2000 work injury caused any fundamental change in Claimant's underlying SLAC wrist. Dr. Lyons, based on her review of x-rays, offered a secondary diagnosis of mild carpal tunnel syndrome.

Dr. Langa reiterated her opinion that Claimant was a suitable candidate for surgery since his conservative care had not resolved his wrist pain. However, she stated that since the surgery is done to relieve the pain symptoms, the decision as to whether to undergo surgery is left up to the patient depending on whether or not their symptoms bother them enough that they wish to undergo surgery. Dr. Langa stated that Claimant informed her that his symptoms did not bother him enough at that point to warrant surgery. She noted that there is nothing that can be surgically done to repair Claimant's wrist to normal.

Dr. Langa addressed her evaluation of Claimant's work restrictions, which were based solely on Claimant's SLAC wrist. She noted that her restriction on lifting up to 40 pounds was based on using both hands. She would limit lifting with Claimant's right hand to 10-20 pounds. Dr. Langa commented that she would restrict Claimant from crawling or from climbing ladders. She stated that she would disagree with Dr. Rehmatullah's restriction of Claimant to sedentary work. Dr. Langa noted that Claimant's grip strength in his right had, which is his dominant hand, was somewhat less than 50% diminished. Dr. Langa opined that she does not believe that Claimant is totally and completely disabled with respect to his wrist, but she didn't know if that opinion would continue into the future because the natural progression of Claimant's post-traumatic arthritis is to gradually progress over time that sometimes results in increasing symptoms. She added that as long as Claimant's symptoms are livable and his wrist is functioning reasonably well, there is no reason to undergo surgery. Dr. Langa stated that, absent any further surgery, Claimant has reached maximum medical improvement.

Dr. McCue was deposed on April 9, 2003. (EX 7). He testified that a small part of his practice is clinical rehabilitation counseling and a large part is serving as an associate professor at a university. Dr. McCue reiterated the findings and conclusions contained in his February 2003 report. He testified that he did not see evidence that Claimant's sensory problems were related to a brain injury. Dr. McCue stated that his findings were similar to Dr. Schwabenbauer's second evaluation findings. He found that Claimant's problems were causally related to his September 12, 2000 injury because they did exist in the severity, nature, and form prior to the accident as they did at the time of his examination. Dr. McCue ruled out Claimant's educational level as a partial cause of the difficulties Claimant is experiencing because problems involving attention and executive functioning are not attributable to intellectual limitations. He also stated that Claimant's age was not likely to be the cause of his problems.

Dr. McCue testified that Claimant has not reached maximum psychological improvement because he believed that a number of treatment approaches would improve Claimant's ability to function psychologically, including impacting Claimant's ability to work every day and Claimant's depression. He would recommend that Claimant undergo cognitive-behavioral psychotherapy to treat his affective symptoms of depression. In conjunction with the therapy, he would prescribe a course of antidepressant medication. Dr. McCue would also recommend a cognitive rehabilitation focus to improve Claimant's executive and memory problems. Lastly, Dr. McCue would recommend a vocational rehabilitation intervention that consists of rehabilitation counseling and work hardening. Depending on the therapist and the individual, Dr. McCue would expect the individual psychotherapy to treat issues associated with worry, lack of interest, lack of motivation, irritability, and complaints of adjustment problems. The cognitive therapy would be done in conjunction with the individual psychotherapy and would be staggered after the affective symptoms are treated. The cognitive rehabilitation would involve devising strategies and accommodations that don't rely on changing Claimant's brain to have an impact on modifying Claimant's situation and providing him with additional tools to reduce the impact of Claimant's cognitive limitations on his day-to-day and vocational functioning. Dr. McCue agreed that his recommendation of cognitive therapy was made without knowing what cognitive training Claimant already received from Nanette Crawford. He stated that his recommendation on work hardening was made without any knowledge of the physical therapy that Claimant had already undergone. Dr. McCue noted that his opinion was limited to Claimant's cognitive and emotional limitations, which would be over and above any limitation caused by physical impairments. Dr. McCue stated that his opinion that Claimant could return to gainful employment in general accounted for Claimant's physical limitations because he recommended a work hardening program. He opined, that aside from Claimant's spelling deficit, the course of treatment that he recommended would not cure the deficits detected through the battery of tests that he conducted; his course of care and treatment would reduce the impact of Claimant's deficits.

At the time he saw Claimant, Dr. McCue stated that Claimant was not capable of returning to gainful employment. He also opined that his recommended course of treatment would be successful in returning Claimant to gainful employment. He assessed the likelihood of success in returning Claimant to work as strong, and he stated that a conservative estimate of the length of time the process would take as one year. Even if his recommendations did not lead to returning Claimant to work, he still believes that they would be helpful to Claimant because it would reduce Claimant's feelings of distress and it would address the everyday cognitive limitations Claimant encounters.

Dr. Lyons was deposed on April 21, 2003. (EX 5). She is a board-certified neurologist. She testified that she first treated Claimant on March 22, 2001 through a referral from Dr. Rehmatullah for Claimant's complaints of headaches and numbness. Dr. Lyons found, through an MRI, that Claimant had a herniated disk in his neck. She noted that the herniated disc did not account for all of Claimant's symptoms. Dr. Lyons recalled her initial impression as being cervical strain, post-concussive syndrome, and numbness spells. After the initial visit, Dr. Lyons stated that she examined Claimant in several follow-up visits. Through an EMG conducted in November 2001, Dr. Lyons diagnosed a mild carpal tunnel in Claimant's right hand. At the time she was seeing Claimant, Dr. Lyons stated that Claimant's neurologic problems in the form of

headaches and sensory symptoms would not have precluded Claimant, but she cautioned that Claimant's neurological problems were not his main problems. Dr. Lyons testified at length regarding the recommendations of Drs. Schwabenbauer and McCue that Claimant attend therapy. She agreed that psychotherapy and the use of antidepressants would help to address Claimant's depression and anxiety. She noted that Claimant's neurological problems did not prevent him from returning to work. However, Dr. Lyons testified that she did not believe that Claimant could return to work as a pipe fitter due to his persistent pain, intermittent sensory symptoms, memory loss, inability to concentrate, and depression. She believed that the use of antidepressants and treatment with psychotherapy would lead to an improved mental state for Claimant in the form of stress management and anti-anxiety management. Dr. Lyons, however, would not testify that antidepressants and psychotherapy would allow Claimant to return to work. She continuously voiced doubt that Claimant would ever return to work again because of the duration his symptoms have persisted. Dr. Lyons thought that antidepressants and psychotherapy would help Claimant deal with his limitations, but she didn't think that it would significantly contribute to his ability to return to gainful employment. She stated that she hasn't seen significant recovery of post-concussive syndrome three years after the injury through treatment of anxiety; she hadn't "seen people be able to return to work." Dr. Lyons allowed that an improvement in Claimant's depression may lead to a little bit of improvement in his cognitive function, but she did not think it would be enough of an improvement to make Claimant able to function on a day-to-day basis in the work environment. If Claimant's depression did improve, she would retest Claimant's cognitive functioning to determine if an improvement had occurred.

Dr. Lyons testified that she did not treat Claimant for problems relating to his neck or wrist. She would defer to Dr. Rehmatullah's opinion or Dr. Lubahn's opinion for questions related to Claimant's neck or wrist. Dr. Lyons mentioned that her opinion in her May 8, 2002 report should read "no limitations regarding his physical capabilities, based upon what [she] gave him and not what (sic) Dr. Rhematullah gave him." Dr. Lyons testified that her finding of no physical limitation was limited to what she treated Claimant for and she deferred on the limitations of Claimant's neck and wrist to Dr. Rehmatullah.

## DISCUSSION AND APPLICABLE LAW

Injury Arising Out of the Course of Employment

The initial issue to be resolved is whether Claimant sustained an injury that now entitles him to benefits under the Act. Claimant alleges that he sustained physical, cognitive, and emotional injuries while working for Employer.

An "injury" is defined in § 902(2) of the Act as an "accidental injury ... arising out of or in the course of employment." § 902(2). The Claimant must initially establish a *prima facie* case that he suffered an injury. To do so, he must show he suffered an injury and that either a work-related accident occurred or that working conditions existed which could have caused or aggravated that injury. *Kelaita v. Triple Machine Shop*, 13 BRBS 326, 330-331 (1981) *See also Cairns v. Matson Terminals, Inc.*, 21 BRBS 252 (1988); *Stevens v. Tacoma Boatbuilding Co.*, 23 BRBS 191 (1990); *Perry v. Carolina Shipping Co.*, 20 BRBS 90 (1987).

If a *prima facie* case of injury is established, the claimant is aided by a presumption pursuant to § 920(a) of the Act that the "injury arose out of and in the course of employment." *Kelaita, supra* at 329-331; *See also Wheatley v. Alder*, 407 F. 2d 307, 312 (D.C. Cir. 1968). The burden then shifts to the employer to produce "substantial evidence to rebut the work-relatedness of the injury." *Volpe v. Northeast Marine Terminals, Inc.*, 671 F. 2d 697, 700 (2nd Cir. 1982), citing *Del Velcchio v. Bowers*, 296 U.S. 280, 285 (1935). After the presumption has been rebutted, the competent evidence must be considered as a whole to determine whether an injury has been established under the Act. *Id.*; *Volpe*, 671 F. 2d 700; *Cairns*, 21 BRBS 252 at 254.

Additionally, if an employment-related injury contributes to, combines with, or aggravates a pre-existing disease or underlying condition, the entire resultant disability is compensable. *Independent Stevedore Co. v. O'Leary*, 357 F.2d 812 (9th Cir. 1966); *Rajotte v. General Dynamics Corp.*, 18 BRBS 85 (1986). Also, when a claimant sustains an injury at work which is followed by the occurrence of a subsequent injury or aggravation outside work, the employer is liable for the entire disability if that subsequent injury is the natural, unavoidable result of the initial work injury. *Bludworth Shipyard v. Lira*, 700 F.2d 1046, 15 BRBS 120 (CRT) (5th Cir. 1983); *Hicks v. Pacific Marine & Supply Co.*, 14 BRBS 549 (1981).

Once an employer offers sufficient evidence to rebut the presumption, the presumption is overcome and it no longer controls the result. *Travelers Ins. Co. v. Belair*, 412 F.2d 297 (1st Cir. 1969); *John W. McGrath Corp. v. Hughes*, 264 F.2d 314 (2d Cir. 1956), *cert. denied*, 360 U.S. 931 (1959); *see also Greenwood v. Army & Air Force Exch. Serv.*, 6 BRBS 365 (1977), *aff'd*, 585 F.2d 791, 9 BRBS 394 (5th Cir. 1978); *Gifford v. John T. Clark & Son, Inc.*, 4 BRBS 210 (1976); *Norat v. Universal Terminal & Stevedoring Corp.*, 3 BRBS 151 (1976). Therefore, the Section 20(a) presumption falls out of the case and the judge must then weigh all the evidence and resolve the case based on the record as a whole. *Swinton*, 554 F.2d 1075, 4 BRBS 466; *Hislop v. Marine Terminals Corp.*, 14 BRBS 927 (1982).

To establish a *prima facie* claim for compensation, a claimant need not affirmatively establish a connection between work and harm. Rather, a claimant has the burden of establishing that (1) he sustained physical harm or pain; and (2) an accident occurred in the course of employment which could have caused the harm or pain.

Once the claimant has availed himself of the presumption, the burden then shifts to the Employer to rebut the presumption with substantial evidence. Substantial evidence is defined as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Sprague v. Director, OWCP*, 688 F.2d 862,865 (1st Cir. 1982). The Board has held that the § 920(a) presumption may be rebutted with evidence specific and comprehensive enough to sever the potential connection between a particular injury and a job-related event. *Swinton v. J. Frank Kelly, Inc.*, 554 F.2d 1075, 1083 (D.C. Cir.), *cert. denied*, 429 U.S. 820 (1976). Thus, the relevant inquiry is whether the Employer's evidence can establish the lack of a causal connection between the Claimant's condition and his employment. *Dower v. General Dynamics Corp.*, 14 BRBS 324 (1981).

The parties stipulated that Claimant suffered an injury that arose out of and in the scope of employment. The evidence clearly establishes that Claimant suffered injuries to his head,

neck, and wrist on September 12, 2000 while in the course and scope of employment for Employer. Therefore, I find that Claimant has suffered an injury arising in the course of his employment.

Nature of Injury

Claimant alleges that he is permanently disabled, while Employer contends that Claimant's injuries are temporary because his condition may be improved through further therapy. Two tests exist to determine whether an injured worker's impairment has changed from temporary to permanent. *See Eckley v. Fibrex & Shipping Co.*, 21 BRBS 120, 122-123 (1988).

Under the first test, a residual disability, partial or total, will be considered permanent if, and when, the injured worker's condition reaches the point of maximum medical improvement ("MMI"). *James v. Pate Stevedoring Co.*, 22 BRBS 271, 274 (1989); *Phillips v. Marine Concrete Structures*, 21 BRBS 233, 235 (1988). Thus, an irreversible condition is permanent *per se*. *Drake v. General Dynamics Corp., Elec. Boat Div.*, 11 BRBS 288, 290 n.2 (1979). The date of the diagnosis of the irreversible condition identifies the date of permanency. *Crouse v. Bath Iron Works Corp.*, 33 BRBS 442 (ALJ May 4, 1999).

Under the second test, a disability will be considered permanent if the injured worker's impairment has continued for a lengthy period and appears to be of a lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. *Watson v. Gulf Stevedore Corp.*, 400 F.2d 469 654 (5th Cir. 1968), *cert. denied*, 394 U.S. 976 (1969). The date of permanency is the date the injured worker stops receiving treatment with a view towards improving his condition. *Leech v. Service Eng'g Co.*, 15 BRBS 18, 21 (1982).

A determination of the date on which an injured worker's impairment became permanent must be established by medical evidence. *See Trask v. Lockheed Shipbuilding & Constr. Co.*, 17 BRBS 56, 60 (1985); *Mason v. Bender Welding & Mach. Co.*, 16 BRBS 307, 309 (1984). The date of permanency may not be based on the speculation of a physician. *Steig v. Lockheed Shipbuilding & Constr. Co.*, 3 BRBS 439, 441 (1976). Both evidence of mental and physical conditions must be assessed when determining if a condition is permanent, since the necessity for psychological treatment for emotional trauma precludes a finding of MMI. *Jenkins v. Kaiser Aluminum & Chem. Sales*, 17 BRBS 183, 187 (1985). However, economic and vocational considerations are not probative of whether an impairment is permanent or temporary. *Ballesteros v. Williamette Western Corp.*, 20 BRBS 184, 186 (1988). The determination of the nature of an injured worker's condition is not affected by the worker's enrollment in a rehabilitation program or the likelihood that he may become gainfully employed as a result. *Price v. Dravo Corp.*, 20 BRBS 94, 96 (1987); *Trask*, 17 BRBS at 60. Moreover, a determination by a vocational expert that an injured worker is unable to return to work cannot form the basis for a finding a permanent disability. *Lusby v. Washington Metro. Area Transit Auth.*, 13 BRBS, 446, 448 (1981).

If the medical evidence establishes that the injured worker's condition is improving and the treating physician anticipates further improvement in the future, it is not reasonable to find that the injured worker has reached MMI. *Dixon v. John J. McMullen & Assocs.*, 19 BRBS 243,

245 (1986). It is also unreasonable to find that MMI has been reached when the treating physician has opined that surgery might be necessary in the future and recommends a follow-up visit in several months to examine for improvement. *Dorsey v. Cooper Stevedoring Co.*, 18 BRBS 25, 32 (1986), *pet. dismissed sub nom. Cooper Stevedoring v. Director, OWCP*, 826 F.2d 1011 (11th Cir. 1987). However, it is reasonable to find permanency if there is only a remote or hypothetical possibility that the injured worker's condition may improve at some future date. *Watson*, 400 F.2d at 654; *Mills v. Marine Repair Serv.*, 21 BRBS 115, 117 (1988); *Walsh v. Vappi Constr. Co.*, 13 BRBS 442, 445 (1981) (prognosis stating that chances of improvement are remote is sufficient to support a finding of permanency). The Benefits Review Board has stated in *dicta* that even a prognosis that improvement and employment are "likely" at some unspecified time in the future does not preclude a finding of permanency. *Walsh,* 13 BRBS at 445. Additionally, if future surgery would only address symptoms of a condition and would fail to alleviate or cure the underlying condition, permanency has been reached. *Bunge Corp. v. Carlisle and T. Michael Kerr, Deputy Assistant Sec. OWCP*, 227 F.3d 934 (7th Cir. 2000). To be permanent, a disability need not be "eternal and everlasting." *Trask*, 17 BRBS at 60, *citing Exxon Corp. v. White*, 9 BRBS 138 (1978). Rather, future favorable changes may be considered in a Section 22 modification proceeding, when and if they occur. *Trask*, 17 BRBS at 60.

Claimant asserts that the injuries he sustained to his wrist, head, and neck have reached MMI based on the medical reports and deposition testimony of Drs. Rehmatullah, Langa, and Lyons. (Claimant's brief, p. 38). Claimant stated that Drs. Lubahn and Langa found that Claimant's wrist does not require surgery. He also stated that his cognitive injuries have reached maximum medical improvement. Employer argues that Claimant has not yet reached "maximum psychological improvement" on the basis of the reports and deposition testimony of Drs. McCue and Schwabenbauer, who opine that Claimant's condition could improve through individual psychotherapy and antidepressants. (Employer's brief, p. 13). Rather, Employer seeks to submit Claimant to the type of care recommended by Dr. McCue and Dr. Schwabenbauer, which may take a year, with Employer paying Claimant temporary total disability benefits during the treatment. Employer did not address Claimant's physical impairments.

Claimant sustained injury to his head, neck, and right wrist on September 12, 2000. From the time of his injury, Dr. Rehmatullah served as Claimant's treating physician. Claimant was also initially followed by Drs. Choi and Clunn. He began attending physical therapy sessions on September 25, 2000, but he stopped after four sessions. Claimant began attending physical therapy again on November 6, 2000. He also began attending speech-language pathology sessions that day with Nanette Crawford. By January of 2001, Claimant had been referred to a hand specialist to evaluate Claimant for the need of wrist fusion to ease the pain in Claimant's right wrist. Claimant continued to complain of pain in his head, neck, and wrist, in addition to sensory problems, dizziness, and headaches. In March of 2001, Claimant was referred to Dr. Lyons for a neurological consultation regarding his right wrist. By that time, Claimant had attended thirty-one physical therapy sessions, but continued to have intermittent cervical spine stiffness, limited cervical spine range of motion, and decreased endurance. Dr. Rehmatullah continued to treat Claimant symptomatically with Darvocet and Vioxx. In July 2001, Dr. Lubahn evaluated Claimant's wrist and advised a conservative approach of symptomatic care over surgery due to Claimant's other injuries and the possibility that the wrist would heal. By August 2001, Dr. Schwabenbauer had determined that Claimant was suffering

from a mild degree of cognitive dysfunction. Claimant continued with speech-language therapy and received a prescription to start a new round of physical therapy in August 2001.

Claimant continued to be treated by Dr. Rehmatullah on a symptomatic basis into 2002. Nanette Crawford discharged Claimant from speech-language therapy in March 2002, noting that he had improved his memory, ability to demonstrate new learning, and comprehension. Dr. Langa conducted an independent medical evaluation in April 2002. Since Claimant's wrist did not bother him enough to warrant surgery, Dr. Langa opined that Claimant had long since reached maximum medical improvement with regard to his wrist. However, she added that it was conceivable that Claimant may require surgery for his wrist in the future. In August of 2002, Dr. Rehmatullah opined that Claimant had reached maximum medical improvement. Dr. Schwabenbauer conducted a follow-up examination to his July 2001 assessment of Claimant. He concluded that Claimant demonstrated mild improvements in some element, but he found that Claimant still continued to demonstrate mild compromise of verbal recall and of complex and attentional processing. He also found that Claimant's depression and anxiety exacerbated his cognitive residual problems. Since two years had passed since Claimant's injury, Dr. Schwabenbauer opined that it was unlikely that any further significant gains would be forthcoming. So, he recommended that Claimant continue to develop compensatory strategies, attend individual therapy to reduce Claimant's anxiety and stress with the hope that it improve Claimant's overall cognitive and emotional function, antidepressant therapy, and work rehabilitation. By December 2002, Nanette Crawford had finished Claimant's speech-language pathology and she discharged Claimant after focusing on compensatory strategies for memory management.

Dr. McCue evaluated Claimant in January and February 2003. He opined, consistent with the opinion of Dr. Schwabenbauer, that Claimant continues to experience mild to moderate cognitive limitations in attention and mental control, limitations in executive functioning, and mild memory impairment. He also found Claimant to be suffering from mild to moderate depressive symptoms. Dr. McCue recommended psychotherapy, cognitive-behavioral orientation, followed by work hardening and vocational intervention. He found that Claimant reached maximum medical improvement, but offered that Claimant could expect significant further functional gains with treatment.

In his February 2003 deposition testimony, Dr. Schwabenbauer asserted that Claimant had reached MMI, noting that the primary recovery period of people with head injuries is 6-12 months. Dr. Schwabenbauer, after acknowledging that Claimant had reached MMI, stated that the therapy he recommended was intended to minimize or alleviate the emotional symptoms. He stated that the therapy would not lead to any further cognitive recovery, but Dr. Schwabenbauer did allow that the therapy would possibly have some impact on Claimant's ability to work. However, Dr. Schwabenbauer then stated that Claimant had reached a plateau in his level of improvement, he reasserted his finding of MMI, and added that medication and therapy may lead to an improvement or worsening in the future.

Nanette Crawford testified in her February 2003 deposition that she provided speech-language pathology therapy to Claimant from November 2000 through December 2002 in three session blocks. Her sessions focused on developing compensatory strategies and improving

Claimant's attention. Therapist Crawford trained Claimant in the use of a day planner and an audible timer to help with his memory deficits. By the end of her third session with Claimant, therapist Crawford stated that Claimant still had difficulty with his memory and attention.

Dr. Rehmatullah's last examination of Claimant in the record was in February 2003. He continued to document Claimant's complaints of tingling at the back of Claimant's head. Claimant also reported pain in his neck, right shoulder, and pain down his right arm, as well as limited mobility and clicking in his right wrist. Dr. Rehmatullah continued to treat Claimant with conservative care through Darvocet and Motrin prescriptions. Dr. Rehmatullah testified during his February 2003 deposition that Claimant had reached MMI on August 20, 2002. He testified that Claimant's future care for his right wrist will be symptomatic care. He also stated that Claimant aggravated his pre-existing neck arthritis on September 12, 2000, and that his neck condition had reached MMI due to the length the symptoms had persisted.

Dr. Langa testified in April 2003 regarding her evaluation of Claimant's right wrist and hand. She concurred with Dr. Lubahn's diagnosis of SLAC wrist. Dr. Langa elaborated on the condition of a SLAC wrist, noting that it was the end-stage of a post-traumatic degenerative process. She testified that, even though no surgery can repair Claimant's wrist to normal, Claimant was a suitable surgical candidate since conservative care had not alleviated his pain. However, since the available surgeries only relieve pain symptoms, the decision on whether or not to undergo surgery is left up to the patient depending on whether the patient's symptoms bother them enough that they would undergo the surgery. Absent surgery, Dr. Langa stated that Claimant had reached MMI with regard to his wrist.

Dr. McCue testified during his April 2003 deposition that Claimant had not reached maximum psychological improvement because a number of treatments remained that would improve Claimant's ability to function psychologically, but he did not address whether Claimant had reached MMI. He stated that his recommended treatment course would help Claimant because it would reduce Claimant's feelings of distress and it would address Claimant's everyday cognitive limitations. The treatment regimen that Dr. McCue recommended included psychotherapy and antidepressants to address Claimant's depression and anxiety, cognitive therapy to help Claimant reduce the impact of his cognitive limitations on his day-to-day life, followed by a work hardening program. Dr. McCue testified that his course of treatment would not cure Claimant's cognitive deficits, rather, his therapy would reduce the impact of those deficits. Dr. McCue opined that his treatment regiment had a strong likelihood of success in returning Claimant to gainful employment.

Dr. Lyons was deposed in April 2003, and she provided testimony regarding her evaluation of Claimant's complaints of headaches and numbness. She stated that she did not treat Claimant for problems relating to his neck or wrist, so she would defer to the opinions of Drs. Lubahn or Rhematullah regarding those problems. She testified that Claimant had persistent pain, intermittent sensory symptoms, memory loss, inability to concentrate, and depression. Upon being questioned regarding the type of therapy recommended by Drs. Schwabenbauer and McCue, Dr. Lyons testified that it would lead to an improved mental state on the part of Claimant, but she had never seen significant recovery from post-concussive syndrome three years after injury through treatment of anxiety. She did allow for the possibility

that an improvement in Claimant's depression could lead to a little bit of improvement in his cognitive function.

I find that the injuries Claimant sustained on September 12, 2000 have reached maximum medical improvement, and they have continued for a lasting duration beyond a normal healing time. The opinions of Drs. Rehmatullah, Lyons, Lubahn, Langa, Schwabenbauer, and McCue establish that Claimant's cognitive, neck, and wrist problems have reached maximum medical improvement.

Drs. Schwabenbauer and McCue both testified that Claimant's cognitive deficits have reached their maximum level of improvement, noting that the primary recovery period for a head injury is six-to-twelve months after the injury. Claimant's difficulties with memory, lack of attention, and lack of concentration have persisted. The therapy regimen recommended by Drs. Schwabenbauer and McCue will not cure Claimant's cognitive deficits, it will only minimize or alleviate the residual symptoms of anxiety and depression. Dr. Lyons stated that she has never seen significant recovery from post-concussive syndrome three years after the event through treatment of anxiety. Even though additional therapy may result in some measure of improvement in Claimant's cognitive function, the evidence establishes that Claimant's cognitive limitations cannot be cured. Cognitive rehabilitation therapy may teach Claimant how to function in everyday life with his cognitive limitations, but it will not improve the limitation. At the time of the hearing, Claimant was more than a year-and-a-half past the primary improvement period of one year. Drs. Schwabenbauer, McCue, and Lyons did not expect any significant improvement in Claimant's cognitive abilities. Even though they believed that their recommended course of treatment could result in some measure of improvement in cognitive function, it is far from a guaranty. In fact, Drs. Schwabenbauer and Lyons both testified that it would be difficult to predict how an individual would react to their recommended course of treatment. Claimant's cognitive limitations have persisted since he was injured on September 12, 2000. He has undergone speech-language pathology therapy and taken antidepressants. Since Claimant's cognitive limitations have persisted for a duration well beyond the primary recovery period, since the recommended treatment only offers a somewhat speculative chance of improvement, and since any improvement would only be in the symptoms and not to the underlying condition, I find that Claimant's cognitive limitations are permanent.

Even though Drs. Langa, Rehmatullah, and Lubahn found that Claimant could reduce the pain he experiences in his right wrist by undergoing a proximal row carpectomy or a wrist fusion, all three acknowledged that those surgeries only reduce pain and they will not return Claimant's wrist to normal. In fact, the proximal row carpectomy and, even more so, the wrist fusion would further reduce Claimant's range of motion in his right wrist. While Claimant's SLAC wrist may further degenerate, become more symptomatic, and eventually require fusion or a proximal row carpectomy, Drs. Langa and Lubahn found that his wrist had reached MMI. As with Claimant's cognitive limitations, a proximal row carpectomy or wrist fusion will only address Claimant's pain symptoms, it will not return Claimant's wrist to normal. Since the medical evidence clearly establishes that Claimant's right wrist has reached MMI, absent surgery, I find that Claimant's SLAC wrist is permanent.

Claimant's feelings of tingling, numbness, dizziness, and headaches have persisted since September 12, 2000, although they varied in severity over that time period. These symptoms are of a lasting and indefinite duration. They have not been resolved through any of the treatments Claimant has undergone. Dr. Lyons, who conducted a neurologic evaluation of Claimant, could not find the cause of these symptoms, nor did she offer a prognosis or treatment plan. These symptoms arose after Claimant's injury, and he did not complain of these symptoms prior to his injury. While Claimant has experienced a lessening in the severity of his headaches and has reported decreases in his other neurological symptoms, they continue cause Claimant discomfort. Claimant's cervical spondylosis has persisted since September 12, 2000. Claimant's neurological symptoms are of a lasting duration. Therefore, I find that Claimant's symptoms of headaches, numbness, and tingling are permanent. Dr. Rehmatullah opined that Claimant's neck had reached maximum medical improvement. There is no medical evidence to the contrary. Therefore, I find that Claimant's cervical spondylosis is permanent.

The medical evidence establishes that Claimant's cognitive limitations, SLAC wrist, cervical spondylosis, and neurological symptoms are permanent.

Extent of Injury

"Disability" under the Act is defined as incapacity as a result of injury to earn wages which the employee was receiving at the time of the injury at the same or any other employment. 33 U.S.C. § 902(10). Thus, in order for an injured worker to receive a disability award, an economic loss coupled with a physical or psychological impairment must be demonstrated. *Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 110 (1991).

Claimant faces the initial burden of establishing that he cannot return to his former employment. *Elliot v. C&P Tel. Co.*, 16 BRBS 89 (1984). If Claimant meets this burden, he is presumed to be totally disabled. *Walker v. Sun Shipbuilding & Dry Dock Co. (Walker II)*, 19 BRBS 171 (1986). Claimant's medical restrictions must be compared with the specific requirements of his usual employment. *Curit v. Bath Iron Works Corp.*, 22 BRBS 100 (1988). "Usual" employment means Claimant's regular work duties at the time he was injured. *Ramirez v. Vessel Jeanne Lou, Inc.*, 14 BRBS 689 (1982); *Moore McCormack Lines v. Quigley*, 178 F.Supp. 837 (S.D.N.Y. 1959).

If Claimant establishes a *prima facie* case of total disability, the burden then shifts to Employer to establish the presence of suitable alternate employment. *Clophus v. Amoso Prod. Co.*, 21 BRBS 261 (1988). Failure by Employer to prove the existence of suitable alternate employment results in a finding of total disability. *Manigault v. Stevens Shipping Co.*, 22 BRBS 332 (1989). Employer must show the existence of realistically available job opportunities within the geographical area where Claimant resides which he is capable of performing, considering his age, education, work experience, and physical restrictions, and which he could secure if he diligently tried. *Lucas v. Louisiana Ins. Guaranty Ass'n*, 28 BRBS 1 (1994); *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031 (5th Cir. 1981); *Armfield v. Shell Offshore, Inc.*, 30 BRBS 122 (1996).

I find that Claimant has established that he is unable to return to his former employment as a pipe fitter. Claimant testified that his work as a pipe fitter involved physical work, which included lifting heavy pipes and wrenches, working overhead, and climbing. Claimant stated that his tools alone weighed forty or fifty pounds each. He was required to pull compressors weighing over fifty pounds. His position involved more of a mental aspect than normal pipe fitting according to Mr. Myers. Sometimes pumps weighing one-hundred pounds were carried. Mr. Call, who was Claimant's supervisor, testified that a pipe fitter would be required to dig trenches, change pipes, install heaters, hitch car was stations, and any general plumbing work. He added that lifting in excess of seventy-five pounds was required on occasion. Mr. Call also stated that a pipe fitter would be required to bend, crouch, stoop, work overhead, and work below. Regarding the mental aspects, Mr. Call testified that they were aspects of safety, such as knowing when to open a water line.

After examining Claimant solely in relation to his right wrist in April 2002, Dr. Langa opined that she didn't believe that Claimant would return to his work as a pipe fitter unless he underwent surgery on his right wrist. However, even if Claimant underwent surgery, there is no guaranty that he could ever return to strenuous work activity. She noted that either available surgical option would result in diminished grip strength. In his state at the time of her examination, Dr. Langa opined that Claimant was only physically capable of performing light/medium work activities that do not require repetitive use of the right wrist. She limited Claimant to lifting up to forty pounds with both hands, and noted that Claimant could not use his right hand for simple grasping, pushing/pulling, or fine manipulation. Dr. Langa elaborated on her imposed restrictions during her April 2003 deposition. Again, noting that her limitations were solely based on the condition of Claimant's right wrist and hand, she stated that Claimant would be limited to lifting up to forty pounds with both hands and no more than ten to twenty pounds with his right hand. She would also restrict Claimant from crawling or climbing ladders. Dr. Langa added that Claimant's grip strength in his right hand, which is his dominant hand, is somewhat less than 50% reduced.

Dr. Rehmatullah, in August 2002, based on Claimant's entire medical condition, restricted Claimant to working no more than four hours per day, lifting no more than ten pounds, and no fine manipulation, and no reaching above his shoulder. Dr. Rehmatullah also restricted Claimant from lifting, bending, squatting, climbing, kneeling, and twisting at all during the day. During his February 2003 deposition, Dr. Rehmatullah noted that Claimant would not be able to return to his work as a pipe fitter when he was discussing why Claimant had not undergone surgery on his right wrist. He also testified as to how the August 2002 limitations he imposed on Claimant were related Claimant's right wrist and neck injuries. Additionally, Dr. Rehmatullah discussed how Claimant's sensory symptoms of unknown etiology limited Claimant's ability to work, such as feelings of dizziness that prevents Claimant from tilting his head back. In February of 2002, Dr. McCue opined that Claimant was not capable of returning to gainful employment as of the time of his report. In his February 2003 deposition, Dr. Scwabenbauer testified that Claimant's cognitive limitations, including problems with attention, concentration, and memory, would significantly interfere with Claimant's ability to work. Nanette Crawford, when evaluating Claimant's ability to work, noted that Claimant was easily distracted by noise when working, continued to experience memory problems, and difficulty following instructions due to his cognitive limitations.

Dr. Lyons, who evaluated Claimant on a neurological basis for his complaints of headaches and numbness, stated that Claimant's neurological problems did not prevent him from returning to work, but added that she did not believe that he could return to work as a pipe fitter due to his persistent pain, intermittent sensory symptoms, memory loss, inability to concentrate, and depression. She concluded that her earlier assessment that Claimant had no physical limitations was limited solely to Claimant's neurological problems and did not account for Claimant's neck and wrist problems since Claimant was being followed by Drs. Lubahn and Rehmatullah, to whom she would defer regarding limitations related to Claimant's neck and wrist.

The evidence overwhelmingly establishes Claimant's inability to return to work as a pipe fitter. The restrictions imposed by Dr. Rehmatullah were reasoned and supported by adequate evidence, which he gathered while serving as Claimant's treating physician since September 13, 2000. Dr. Rehmatullah based his restrictions on Claimant's condition as a whole. The physicians who evaluated Claimant on limited basis according to their specialty, imposed restrictions based on Claimant's individual conditions alone that would prevent him from returning to work as a pipe fitter. Claimant's right wrist prevents him from lifting the heavy objects or from performing the fine manipulations required to perform his work. His neck condition limits his ability to work overhead, as do his dizziness symptoms. Claimant's cognitive limitations also preclude him from returning to work as a pipe fitter, since his diminished attention, focus, and memory inhibit his ability to follow instructions. Therefore, I find that Claimant cannot return to work as a pipe fitter. Claimant has established a *prima facie* case of total disability. Thus, the burden shifts to Employer to prevent evidence of suitable alternate employment.

Employer did not adduce any evidence of suitable alternate employment. The only vocational evidence offered was the narrative opinion and deposition testimony of Dr. Durgin, which was adduced by Claimant. Dr. Durgin opined, based on his interview with Claimant and Claimant's physical/exertional limitations, age, lack of transferable skills, and lack of access to jobs in his labor market, that Claimant is completely unemployable. Dr. Durgin relied upon a computerized vocational analysis, which accounted for the above noted factors, that revealed that Claimant's vocational profile constitutes 0.19% of the jobs existing in his local labor market. Upon cross-examination from counsel for Employer, Dr. Durgin admitted that he did not identify with specificity what the 0.19% of the jobs available to Claimant were. However, he did testify, based on his experience, that Claimant is not "going to get the jobs because he's 59 years old and he's a disabled worker trying to get two-tenths of 1 percent of the jobs in his local labor market." He opined that there were simply no jobs that Claimant could compete for in his labor market.

Employer did not offer any evidence of suitable alternate employment. Dr. Durgin's opinion establishes that Claimant is unemployable based on his physical/exertional limitations, age, and lack of transferable skills. He also testified that, realistically, there are no jobs that Clamant will be able to compete for. Therefore, I find that Claimant is totally disabled. Since I have determined that Claimant suffers from a permanent total disability, it is not necessary to determine when Claimant is entitled to permanent partial disability compensation based on scheduled injuries.

Compensation

Claimant has established that he sustained a work-related injury that led to a permanent total disability. "In the case of total disability adjudged to be permanent $66^{2/3}$ per centum of the average weekly wages shall be paid to the employee during the continuance of such total disability." 33 U.S.C. § 908(a). The parties stipulated that Claimant's average weekly wage was $638.28. Therefore, I find that Claimant is entitled to $66^{2/3}$ per centum of $638.28, which amounts to $425.47, for the duration of his permanent total disability.

Date of Onset of Benefits

Based on the reports and testimony of Drs. Rehmatullah, Langa, Schwabenbauer, and McCue, I find that Claimant had reached maximum medical improvement by August 20, 2002. Thus, Claimant has been entitled to permanent total disability since August 20, 2002. The parties stipulated that Claimant has received temporary total disability benefits from September 12, 2000 to the present at a rate of $425.01. Since Employer has voluntarily paid temporary total disability compensation to Claimant from the time of his injury to the present, I find that Claimant shall be entitled to receive compensation for permanent total disability from the date of the issuance of this order and it shall continue for the duration of Claimant's permanent total disability. Additionally, Claimant shall be entitled to receive a lump sum payment to be calculated by the $0.46 difference between the $425.47 he is entitled to on the basis of his permanent total disability and the $425.01 that Employer voluntarily paid in temporary total disability for the period beginning on August 20, 2002 and lasting until the date of the issuance of this order.

Medical Benefits

Claimant has established that he suffers from a permanent total disability arising out of work-related injuries to his head, neck, and right wrist, as well as cognitive limitations. Under § 907(a), employers are required to furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require. I find that Employer shall furnish such medical, surgical, and other attendance or treatment as Claimant's may require in accordance with § 907. For instance, Drs. Lubahn, Langa, and Rehmatullah have found Claimant to be a suitable surgical candidate for treatment of Claimant's SLAC right wrist. Since the two available surgeries only relieve Claimant's pain symptoms, the physicians allowed Claimant to decide whether or not he wants to receive surgical intervention. As of the date of issuance of this order, Claimant has not found surgical intervention to be necessary. However, Dr. Langa has testified that Claimant's wrist condition is degenerative and may require surgery in the future if the symptoms related to Claimant's SLAC wrist intensify. Additionally, Drs. Schwabenbauer and McCue have recommended that Claimant undergo individual psychotherapy in conjunction with a prescription antidepressant medication therapy, which is to be followed by cognitive rehabilitation therapy and work hardening. Employer shall provide Claimant with this necessary treatment.

Attorney Fees

Counsel for Claimant has submitted a fee application. However, counsel for Employer has requested that the undersigned allow Employer a period of time after the issuance of a decision and order to respond to the fee petition. A period of 21 days is hereby allowed for Employer's counsel to submit a response to counsel for Claimant's fee application. The response to the fee application of counsel for Claimant must respond to the fee petition in accordance with 20 C.F.R. § 702.132, which sets forth the criteria on which the request for fees will be considered. Therefore,

## ORDER

IT IS ORDERED that:

1. Claimant, Thomas Bordeaux, suffered a work-related injury on September 12, 2000, while employed by Pittsburgh & Conneaut Dock & Signal Administration, which has resulted in a permanent and total disability that reached maximum medical improvement by August 20, 2002;

2. Employer, Pittsburgh & Conneaut Dock and Signal Administration, shall pay Claimant, Thomas Bordeaux, the amount of $425.47 for the duration of his permanent total disability;

3. Employer, Pittsburgh & Conneaut Dock and Signal Administration, shall pay Claimant, Thomas Bordeaux, the sum of the $0.46 difference between the $425.47 Claimant is entitled to in the form of permanent total disability compensation dating back to August 20, 2002 and the $425.01 Employer paid Claimant as temporary total disability for the period of August 20, 2002 through date of the issuance of this order;

4. Employer, Pittsburgh & Conneaut Dock and Signal Administration, shall pay Claimant, Thomas Bordeaux, any necessary and reasonable medical expenses relating to his work-related injuries in accordance with § 907;

5. Employer, Pittsburgh & Conneaut Dock and Signal Administration, shall pay Claimant, Thomas Bordeaux, interest on the accrued benefits created by the difference between the rate of temporary total disability compensation Employer paid Claimant from August 20, 2002 through the date of issuance of this decision and the rate the undersigned awarded Claimant for permanent total disability at the rate applicable under 28 U.S.C. § 1961 (1982), computed from the date each payment was originally due until paid. The appropriate rate shall be determined as of the date of filing of this Decision and Order with the District Director; and

6. Counsel for Employer shall file a response to the petition for attorney fees filed by counsel for Claimant within 21 days of the issuance this decision in compliance with 20 C.F.R. § 702.132.

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THOMAS F. PHALEN, JR.
Administrative Law Judge